MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12556

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Silver Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 years

Hospital, institution, or street address where death occurred:

4590 - St. Barnabas Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Silver Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4590 - St. Barnabas Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Richard Anthony Allen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1859

8. AGE: Years 86 | Months 3 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Silver Hill, Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

FATHER 12. Name James Allen

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Susan Smith

MOTHER 15. Birthplace Maryland

16. Informant Florence Berry

Address 4590 Saints Barnabas Rd

17. Burial Date thereof 1-2-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bells Church

Location Camp Springs, Md.

18. Funeral director W. W. Chamberlain & Co

Address 517 11th St. S.E.

19. Dec. 30th 1945 Thos S. Griffith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1945 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardio macular renal disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Deputy Medical Examiner

Edmund D. Ford M. D. or other

Address Forestville Md. Date signed 12-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64-2)

CERTIFICATE OF DEATH

12557

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Daniels Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

5014 Georgia Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Floyd Alvin Benjamin

3.(b) Social Security Number 216-05-8622

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Pauline Benjamin

6.(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) July 26, 1909

8. AGE:	Years	Months	Days	If less than one day
	36	4	21	...hrs. ...min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Bottle Washer

11. Industry or business Dairy

FATHER 12. Name B. B. Benjamin

13. Birthplace Virginia

MOTHER 14. Maiden name Nellie Nightstyler

15. Birthplace Virginia

16. Informant Willard L. Benjamin

Address 4709 Tuckerman St, Edmonston, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 12-20-45 (month) (day) (year)

Cemetery or crematory Ft. Lincoln Cemetery

Location Washington D.C.

18. Funeral director W.W. Chambers Co.

Address Riverdale, Md.

19. December 20 1945 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945, at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Gun shot wound of Chest	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 12-17-45

Where did injury occur? Daniels Park P.G. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) In garage back of them

Means of injury Shot self with pistol Injured at work? No

Reported Medical Examiner

23. SIGNATURE ... M. D. or other

Address Forestville Md Date signed 12-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12558

Reg. Dist. No. 230

1. PLACE OF DEATH
County Pro Geo co
City or town Beltsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pro Geo co
City or town Beltsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Sunnyside Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Vergie B. Bladen.

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Charles Bladen
6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1887.

8. AGE: Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Henry A. Chapman
13. Birthplace England.

MOTHER
14. Maiden name Sarah A. Burrough
15. Birthplace Md

16. Informant Mrs Frances Miller
Address Sargeant Rd Chillum Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 28, 1945 (month) (day) (year)
Cemetery or crematory Rock Creek Cemetery
Location Washington D.C.

18. Funeral director J. Paschia sons
Address Hyattsville Md.

19. Dec 27th 1945 (Date rec'd by registrar) Johan D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25, 1945, at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 24 1945, to 12/25 1945 and that I last saw h[illegible] alive on December 25 1945

Immediate cause of death	DURATION
Dissecting Aneurysm of the thoracic Aorta	12 hr
Due to Essential Hypertension	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. Louis Mandel M.D.
M. D. or other
Address College Park Md Date signed 12/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

12559

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Maryland Park.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 months
Hospital, institution, or street address where death occurred:
6532 - C Street
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo.
City or town: Maryland Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6532 - C Street.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: RoseAnne Bolton

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow.

6.(b) Name of husband or wife: John Williams Bolton. 6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 24, 1860

8. AGE:

Years	Months	Days	If less than one day
85			...hrs. ...min.

9. Birthplace: County Tyrone, Ireland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Joseph Bolton
Address 6532 C St, Md Pk, Wash 19, DC

17. removal (Burial, cremation, or removal. Which?) Date thereof Dec 9 1945 (month) (day) (year)
Cemetery or crematory: Washington DC
Location:

18. Funeral director: W. W. Chamberlain Co
Address 519 - 11 st SE. Wash DC

19. DEC 9 1945 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9 1945, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1945, to Dec. 9 1945
and that I last saw h... alive on December 9 1945

Immediate cause of death: Carcinoma of Scalp. — DURATION: 5 years
Brain Metastases — 3 days
Due to:
Due to:
Other conditions: Generalized arteriosclerosis — 15 years
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William Brainin M. D.
Address: Capitol Hgts, Md Date signed: 12/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

12560

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3104. Longfellow st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Eliza Josephine Erana Bonar

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Ernest von Bonar
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 21. 1859.

8. AGE: Years: 86 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pa (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: G. W. Erana
13. Birthplace: Pa

MOTHER
14. Maiden name: Rebecca Porter
15. Birthplace: Pa

16. Informant: Mary E. Bonar
Address: Hyattsville Md.

17. Disposition: transportation (Burial, cremation, or removal. Which?) Date thereof: Dec 8, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Rose Cemetery
Location: Moundsville W. Va

18. Funeral director: F Gaschia sons
Address: Hyattsville Md.

19. Dec 8" 1945 (Date rec'd by registrar) James Leary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8. 1945, 19 ..., at 6:20 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 12 1945, to Dec 8 1945 and that I last saw h.. alive on 12-5-45 19 ...

Immediate cause of death	DURATION
Peritonitis, Multiple	6 days
Intestinal Fistulas	6 wks
Due to: Appendiceal abscess	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John P. Clum M.D. M. D. or other
Address: Hyattsville Md Date signed 12-8-45

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12561

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Brentwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3913 - Newark Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: James Boothby

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 24 - 1873

8. AGE: Years: 72 | Months: 10 | Days: 24 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Nicholas Boothby

13. Birthplace: Ohio

MOTHER

14. Maiden name: Rebecca Smith

15. Birthplace: Ohio

16. Informant: daughter - Mrs Florence Attemus

Address: 3913 Newark Rd, Brentwood, Md.

17. transportation (Burial, cremation, or removal. Which?) Date thereof: Dec 18. 1945 (month) (day) (year)

Cemetery or crematory: Oakley Ohio

Location: Oakley Ohio

18. Funeral director: F Cuccia sons

Address: Hyattsville Md.

19. 12/18 1945 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 18 1945 at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27, 1945 to December 18 1945

and that I last saw him alive on December 17, 1945

Immediate cause of death	DURATION
Chronic Congestive Heart Failure	4 months
Due to	
Due to	
Other conditions: Anasarca	4 months

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Mt Rainier Md Date signed 12/18/45

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-F)

CERTIFICATE OF DEATH

12562

232

Reg. Dist. No.

1. PLACE OF DEATH:
County Prince George
City or town Upper Marlboro, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William George Brooke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

8.(b) Name of husband or wife Anna Hill
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26-1865.

8. AGE:

Years	Months	Days	If less than one day
80	—	24	hrs. min.

9. Birthplace Leland R. Fac. Co., Md.
(Town, county, and state)
10. Usual occupation Attorney-at-law
11. Industry or business

FATHER
12. Name John Brown Brooke
13. Birthplace Rosaryville, Md.

MOTHER
14. Maiden name Ellen Hill
15. Birthplace Upper Marlboro, Md.

16. Informant William Hill Brooke
Address Upper Marlboro, Md.

17. Burial, Date thereof 12-22-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Carmel
Location Upper Marlboro, Md.

18. Funeral director Ritchie Brothers
Address Upper Marlboro, Md.

19. Dec 21 19 45 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 19 45 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 18 19 45 to Dec 20 19 45
and that I last saw h[illegible] alive on Dec 20 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	4 days.
Due to	
Due to	
Other conditions Nephritis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James L. Spencer M. D. or other
Address Upper Marlboro, Md. Date signed 12-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12563

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Several years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince Georges

City or town: Mount Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3809 - 37th st.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Susie L. Burkhart

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Michael H.

6.(c) If alive, give age: XXX years

7. Birth date of deceased (mo., day, yr.): June 25th 1867

8. AGE: Years	Months	Days	If less than one day
78	5	28	hrs. min.

9. Birthplace: Howard County, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace: Md.

MOTHER — 14. Maiden name: Catherine Leakins

15. Birthplace: Md.

16. Informant: Mrs Achsah B. Harder

Address: 3809 - 37th st. Mt Rainier Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 26th 1945 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Washington D.C. Prince Georges Co. Md.

18. Funeral director: R. F. Chambers Co.

Address: Riverdale, Md.

19. Dec 26th 1945 James Seery

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sun. Dec. 23rd 1945, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22, 1945, to Dec. 23, 1945, and that I last saw her alive on December 22, 1945.

	DURATION
Immediate cause of death: Pulmonary Infarction	Sev. days.
Due to:	
Due to:	
Other conditions: Generalized arteriosclerosis	1 year
Cardio vascular renal disease (Include pregnancy within 3 months of death)	Sev. months.

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Leslie Levine M.D. M. D. or other

Address: Mt. Rainier, Md. Date signed: 12/24/45

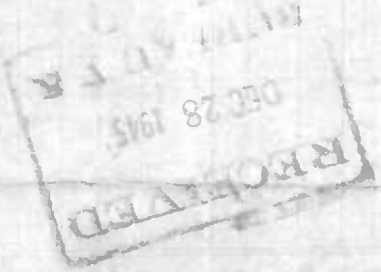
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

12/23/45

Coroner to tipe and
will appear



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12564

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 1 mo., 13 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 yrs., 1 mo., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County: Washington

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1529 - 7th St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Joseph Chatman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colores	Single

B.(b) Name of husband or wife: —

B.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): November 9, 1888

8. AGE: Years	Months	Days	If less than one day
57	1	2	...hrs. ...min.

9. Birthplace: Anniston, Alabama
(Town, county, and state)

10. Usual occupation: Plasterer

11. Industry or business:

FATHER
12. Name: Tom Chatman
13. Birthplace: Talladiga, Alabama

MOTHER
14. Maiden name: Fanny Weaver
15. Birthplace: Anniston, Alabama

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12-14-45 (month) (day) (year)

Cemetery or crematory: District Morgue

Location: Washington D.C.

18. Funeral director: Remains unclaimed
Address:

19. Dec. 11, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 11 1945, at 6 05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-27-43 19... to 12-11 19 45 and that I last saw h... alive on 12-10 19 45

Immediate cause of death	DURATION
Pulmonary tuberculosis	2 yrs 1 mon
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Daniel Lee Pincare MD
M. D. or other

Address: Glenn Dale Md Date signed 12-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

ITEM 6b: aff. of JOHN HACKETT, atty. for wife; certified copy of marr. cer. of 11-19-22 Montg.Co. Md. proving below; filmed 12-10-47 GLB,-LL

12565

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or Institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3103 Windham Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clagett Mr. Markell J.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	married

6.(b) Name of husband or wife: IDA VIRGINIA Clagett, Mabel Woodruff (nee Cecil)
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1896

8. AGE: Years	Months	Days	If less than one day
49	3		..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: Clerk, & Laborer
11. Industry or business: " "

MOTHER FATHER
12. Name: Edgar Clagett
13. Birthplace: Md.
MOTHER
14. Maiden name: Mattie Harris
15. Birthplace: D.C.

16. Informant: Mrs. Dorothy Clagett
Address: 3103 Windham Rd, Mt. Rainier

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/20/45 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg Md.
18. Funeral director: Ernest C. Gantner
Address: Gaithersburg Md.

19. 12/18 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 18 1945, at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4 1945 to Dec. 18 1945 and that I last saw him alive on Dec. 18 1945

Immediate cause of death	DURATION
Pneumonia, Lobar;	10 days
Due to: CWLP.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Irvin M. Grossgreen M.D.
M. D. or other
Address: Mt. Rainier, Md. Date signed 12-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33(a)

CERTIFICATE OF DEATH

12566

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince Georges
City or town: Laurel - Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred: Warren Hospital - Laurel Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: P. Geo. C.
City or town: Ammendale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Michael Cody

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): ? 1870

8. AGE: Years 75 | Months | Days | If less than one day: hrs. min.

9. Birthplace (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business
FATHER 12. Name: unknown
13. Birthplace: U
MOTHER 14. Maiden name: U
15. Birthplace: U
16. Informant: Brother Eelas
Address: Ammendale Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-2-46 (month) (day) (year)
Cemetery or crematory: Ammendale Cemetry
Location: Ammendale Md
18. Funeral director: Wedhamber Co
Address: Riverdale Md
19. Dec 31 1945 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-29- 1945, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-27- 1945 to 12-29 1945 and that I last saw h.. alive on Dec 29 1945

	DURATION
Immediate cause of death: Bronchopneumonia	2 day
Due to: Influenza	2 day
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: J M Warren M D
M. D. or other
Address: Laurel Date signed 12/31/45

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (M) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (482)

12567 242

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:
County: Pr. Geo's Co.
City or town: Dillon Park S. E.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo's Co.
City or town: Dillon Park S. E.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5211- H. St. Dillon Park S. E. Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nellie B. Connelly

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas J. Connelly
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 10th. 1871

8. AGE: Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: Conn. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Patrick Bracken
13. Birthplace: Conn,
MOTHER 14. Maiden name: Bridget Cain
15. Birthplace: Conn.
16. Informant: Mrs. Louis E. Beall
Address: 5211- H. St. Dillion Park. S. E. Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Dec - 22 - 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Maryland
18. Funeral director: Thomas F. Murray
Address: 2017- nichols ave SE Wash DC
19. Dec 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20th. 1945 at 4-A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 13 1945, to dec. 20 1945
and that I last saw h. alive on dec. 19 1945

Immediate cause of death	DURATION
Carcinoma of Rectum	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Rectum (Colostomy performed) Date of op. July 5 - 1946
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Roger S. Williams M.D. M. D. or other
Address: 35 New York Ave. N.W. Date signed: 12/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12568

Reg. Diat. No. 243.

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 201 - 12th St. N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME HOWARD COSEY

3.(b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 15, 1903

8. AGE: Years	Months	Days	If less than one day
41	11	21	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Mover

11. Industry or business:

FATHER
12. Name: Louis Cosey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eliza Stewart
15. Birthplace: Maryland

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec. 6, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D. C.

18. Funeral director: J. D. Lemar

Address: 1504 ME

19. Dec. 6, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6, 1945, at 5-55- A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15, 1945, to Dec 6, 1945

and that I last saw h/ll alive on Dec 6, 1945

Immediate cause of death	DURATION
Tuberculous Tuberculosis	4 MO
Due to Tuberculer Laryngitis	4 MO
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed 12/6/45

M. (1) VS A15-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

12569

★ Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Geo.

City or town: Glenarden

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since birth

Hospital, Institution, or street address where death occurred: Prince Georges General Hospital.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince Geo.

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 7014 - D St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CHARLES DAVID CRUMP

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	N	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 18 45

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: James R. Crump.

13. Birthplace: Ala.

MOTHER — 14. Maiden name: Helen L. Ellis

15. Birthplace: Texas

16. Informant: Helen L. Crump

Address: 7014 - D St. Seat Pleasant Md

17. Burial, cremation, or removal. Which?: Burial Date thereof: 12/3/45 (month) (day) (year)

Cemetery or crematory: Mt. Lubentia

Location: Bladensburg Md.

18. Funeral director: Smith Columbia Co.

Address: 517 - 11 St. N.E.

19. Dec 1st 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 1 1945 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 23 1945 to Dec 1 1945 and that I last saw h alive on Dec 1 1945

Immediate cause of death	DURATION
Pneumonia	3 day
Due to Prematurity	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dorothy Jaeger M.D.

Address: 2146 Wyoming Ave N.W. M. D. or other

Date signed: 12/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (105a)

CERTIFICATE OF DEATH

12574

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Pro Geo co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4103 Gallatin st
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Louis Plastiell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 31. 1877

8. AGE: Years: 68 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: asst sect

11. Industry or business: Canners association

MOTHER FATHER
12. Name: Hampden Haney Plastiell
13. Birthplace: Pa
14. Maiden name: Elizabeth Polk
15. Birthplace: Md

16. Informant: Jessie Plastiell
Address: Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 29. 1945 (month) (day) (year)
Cemetery or crematory: Lot Lincoln
Location: Colmar Manor Md

18. Funeral director: F Gasch's sons
Address: Hyattsville Md.

19. Dec 29 1945 (Date rec'd by registrar) James Severs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 29, 1945, at 5:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to Dec 27 1945 and that I last saw h.x.x.. alive on Dec 27 1945

Immediate cause of death	DURATION
Cardiac dilatation	1 Wk
Due to: Acute Bronchitis	3 wks
Due to: Arteriosclerosis Generalized	11 years
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No
Date of op.:
Autopsy results: V
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo W Fechtig M D
M. D. or other
Address: Hyattsville Md Date signed 12-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12571

CERTIFICATE OF DEATH

Reg. Diat. No. 243.

1. PLACE OF DEATH:

County: Prince Georges County

City or town: Glenn Dale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months, 27 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 6 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2523- 14'th St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: JOHN DORSEY

3.(b) Social Security Number: 579-03-0631

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widowed

6.(b) Name of husband or wife: Willie Dorsey

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13, 1899

8. AGE:	Years	Months	Days	If less than one day
	46	8	5	hrs. min.

9. Birthplace: Howard, Maryland
(Town, county, and state)

10. Usual occupation: Fireman, Apartment House

11. Industry or business: -

FATHER — 12. Name: John Dorsey

13. Birthplace: unknown

MOTHER — 14. Maiden name: Lulu Hopkins

15. Birthplace: Howard, Maryland

16. Informant: decedent

Address

17. (Burial, cremation, or removal. Which?) Removal — Date thereof: 12-19-45 (month) (day) (year)

Cemetery or crematory: To Wash. D.C.

Location

18. Funeral director: W Ernest Jarvis Co.

Address: 1432 You St NW

19. (Date rec'd by registrar) Dec. 18, 1945 — Rowland S. Phillips, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 18 1945 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21 1945 to Dec 18 1945 and that I last saw h... alive on Dec. 18, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)

Address: Glenn Dale, Md. Date signed: 12/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12572

CERTIFICATE OF DEATH

★ Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days 9 hrs. 25"
Hospital, institution, or street address where death occurred:
Prince Georges Hospital
How long in hospital or institution? 13 days 9 hrs. 25 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4110 53rd. ave. apt. 2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Ladie B. Downing

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 5 1880

8. AGE: Years: 65 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: D. C.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Henry J. Rhean
13. Birthplace: Md.

MOTHER
14. Maiden name: Julia A. Casey
15. Birthplace: Ireland

16. Informant: Mrs. Dorothy Wood
Address: Same

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: 12-19-45
(month) (day) (year)
Cemetery or crematory: Glenwood
Location: Washington D.C.

18. Funeral director: J. Wm. Leis Sons Co.
Address: Washington D.C.

19. 12/17 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-16 1945, at 5 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Dec 16 1945
and that I last saw h.er alive on Dec 15 1945

Immediate cause of death	DURATION
Carcinoma uterus	
Due to	
Due to	
Other conditions: Cancer Cachexia.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. M. Downing M. D.
Address: Prince Geo Hosp. M.D. or other
Date signed: 12-16-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

12573 45

Reg. Diat. No. .....

1. PLACE OF DEATH:
County Prince Georges Co. Maryland
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Sacred Heart Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5801 Queens Chapel Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Maria Draine

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

8.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years 90 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Chas. Draine
13. Birthplace Ireland

MOTHER 14. Maiden name Mary McLeod
15. Birthplace Ireland

16. Informant Sacred Heart Home Records
Address Hyattsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-4-45 (month) (day) (year)
Cemetery or crematory
Location Washington D.C.

18. Funeral director The S.H. Hines Co.
Address 2901 - 14th St. N.W.

19. Dec 1 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 19 45 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 19 45 to Dec 1 19 45
and that I last saw h alive on Dec 1 19 45

Immediate cause of death	DURATION
Senile Debility	1 year
Due to	
Due to	
Other conditions Senile Dementia	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Mildred Brady M. D. or other
Address 5801 Queens Chapel Rd. Date signed Dec 1 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1702)

CERTIFICATE OF DEATH

1257 ★ Reg. Dist. No. 248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7½ hours

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Instrument Park (If outside city or town limits, write RURAL and give nearest town)

Street No. 6505 - 44th Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mamie Magelene Duncan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 12, 1919

8. AGE: Years	Months	Days	If less than one day
26	1	3	hrs. min.

9. Birthplace: Roxboro, N. C. (Town, county, and state)

10. Usual occupation: Secretary

11. Industry or business: George Washington Univ.

FATHER 12. Name: Daniel Clyde Duncan

13. Birthplace: N. C.

MOTHER 14. Maiden name: Ida Irene Clayton

15. Birthplace: N. C.

16. Informant: Mrs Ida I. Duncan

Address: R.F.D. #1, Petersburg, Va

17. Burial, cremation, or removal. (Which?) By train Date thereof: 12-15-45 (month) (day) (year)

Cemetery or crematory: Petersburg Cemetery

Location: Petersburg, Va

18. Funeral director: W W Chambers Co.

Address: Riverdale, Md

19. Dec 15 1945 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 15 1945, at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Intra Cranial hemorrhage	
Due to: Fracture of base of skull	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 12-14-45

Where did injury occur? Instrument Park P.5 Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Route #1

Means of injury: Pedestrian struck by Car Injured at work?

Deputy medical Examiner

23. SIGNATURE: ... M. D. or other

Address: Forestville Md Date signed: 2-15-46

12575

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-L)

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH: (WITHIN CORPORATE LIMITS OF)

County Prince George

City or town Laurel (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred: Larsen's Hospital Laurel, Md.

How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Pr. George's

City or town Laurel (If outside city or town limits, write RURAL and give nearest town)

Street No. 322 Laurel Ave (If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Minnie Hester Carp

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Nicholas B. Carp

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 20, 1857

8. AGE: Years 88 | Months 7 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace Laurel, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER — 12. Name Chauncey C. Hester

FATHER — 13. Birthplace Massachusetts

MOTHER — 14. Maiden name Mary R. Todd

MOTHER — 15. Birthplace Massachusetts

16. Informant Lillian Carp

Address Laurel, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 22 1945 (month) (day) (year)

Cemetery or crematory Mary Hill Cemetery

Location Laurel, Md.

18. Funeral director De Witt Vandiver

Address Laurel, Maryland

19. Dec 22 1945 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1945, at 10:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1941, to Dec 19 1945

and that I last saw h.. alive on Dec 17 1945

Immediate cause of death Cachexia

Myocarditis

Due to Carcoma R. Femur

Due to .....

Other conditions Arteriosclerosis

Hypertension

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. M. Warren M.D. M. D. or other

Address Laurel Date signed 12/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

12576

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5900 - Cleveland ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MARGARET EICHHORN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: x xx

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 1st 1870

8. AGE:

Years	Months	Days	If less than one day
75	3	28	..... hrs. ..... min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: None.

11. Industry or business:

FATHER
12. Name: Rudolph Eichhorn
13. Birthplace: D.C.

MOTHER
14. Maiden name: Ann E. Coulan
15. Birthplace: D.C.

16. Informant: Miss Nellie Eichhorn
Address: 5900 - Cleveland ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31, 1945 (month) (day) (year)
Cemetery or crematory: Glenwood Cemetery
Location: Washington D. C.

18. Funeral director: W. H. Chambers Co.
Address: Riverdale Md.

19. Dec 30 1945 (Date rec'd by registrar) James Devery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28th 1945 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 20, 1945 to December 28, 1945 and that I last saw her alive on December 26, 1945

Immediate cause of death	DURATION
Cardiovascular renal disease	One year
Due to	
Due to	
Other conditions: Generalized arteriosclerosis	one year

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

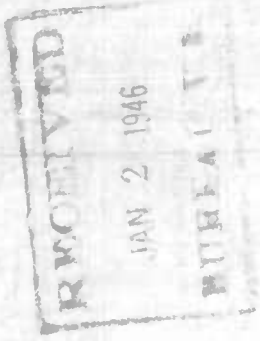
23. SIGNATURE: [signature] M. D. or other
Address: Mt. Rainier, Md. Date signed 12.30.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Coroner, Dr. James I. Boyd, adopted by me on December 28, 1945; law will approve.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

12577

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH: County Dr. Geo. C. City or town Lovelaverstells md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Dr. Geo. C

City or town Lovelaverstells (If outside city or town limits, write RURAL and give nearest town)

Street No. 408 Beall st (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John W. Ferdmann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife Minnie Ferdmann 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19-1869

8. AGE: Years 76 Months Days If less than one day hrs. min.

9. Birthplace Wash Dc. (Town, county, and state)

10. Usual occupation Butcher, retired

11. Industry or business

FATHER 12. Name Frederick Ferdmann

13. Birthplace D. C.

MOTHER 14. Maiden name — Scholl

15. Birthplace D.C.

16. Informant Gladys Beckwith, Dtr.

Address 209 Trinidad St. N.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-4-45 (month) (day) (year)

Cemetery or crematory Prospect Hill Cemetery

Location Wash. D.C.

18. Funeral director Lowchambes Co

Address Riverdale md

19. 12/3 19 45 Amanda Downey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1- 1945 at 8550 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 24 1945, to December 1, 1945 and that I last saw h... alive on December 1, 1945

Immediate cause of death	DURATION
Bronchopneumonia	one week
Due to	
Due to	
Other conditions Generalized Arteriosclerosis	Several months
Coronary Heart Disease	Several months

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Riverdale Md Date signed 12/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

12578

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George Co.

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs.

Hospital, Institution, or street address where death occurred: Home 119 3rd Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George Co.

City or town Takoma Park Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 119 - 3rd. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George F. Forman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 27, 1865

8. AGE: Years	Months	Days	If less than one day
80	7	1	hrs. ..... min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Retired Plasterer

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant Horace Forman

Address 119 - 3rd Ave. Takoma Park.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec 26 1945 (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Wash. D.C.

18. Funeral director Arthur Miller

Address 254 - Carroll St. N.W.

19. Dec. 23 1945 (Date rec'd by registrar) Jean Severy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1945, at 6:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 8, 1945, to Dec. 23, 1945, and that I last saw him alive on Dec. 22, 1945.

	DURATION
Immediate cause of death: Congestive heart failure	15 days
Due to: Arteriosclerosis	2 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE C. B. Settle M.D. M. D. or other

Address 6911 16th N.W. Washington D.C. Date signed 12/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1257 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5351 - Hayes St. N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME GLADYS GIBSON

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 17, 1916

8. AGE: Years	Months	Days	If less than one day
29	7	23	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Printer's Helper - Bur. of Eng.

11. Industry or business:

FATHER
12. Name: Charles Gibson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Estelle Buckner
15. Birthplace: Virginia

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12 - 10 - 45 (month) (day) (year)

Cemetery or crematory: To Washington DC

Location:

18. Funeral director: Henry S. Washington & Sons

Address: 467 - N. Capitol N. W.

19. Dec. 10, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 10 1945, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOV. 23 1945, to DEC. 10 1945 and that I last saw h.e.r. alive on DECEMBER 10 1945

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	6 mos
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed 12/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B—Every item of information should be carefully supplied ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1258

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2-42

[1] PLACE OF DEATH

County Prince Georges

Village or City Fairmont Hghts (No. 703 Eastern Avenue St.: Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

[2] FULL NAME Pearl Gibson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Female	Colored	X

6 DATE OF BIRTH: April (Month) 15 (Day), 1879 (Year)

7 AGE: 66 yrs. mos. ds. If LESS than 1 day hrs. or min.

8 OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed or (employer):

9 BIRTHPLACE (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Joseph Cooper

11 BIRTHPLACE OF FATHER (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Hester Harris

13 BIRTHPLACE OF MOTHER (State or country): South Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nathan Gibson

(Address) 703 Eastern Avenue

15 Filed 12-15 1945 Carrie F. Campbell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 12th (Day) 45 (Year) 192

17 I HEREBY CERTIFY, That I attended the deceased from 192 . to , 192 , that I last saw her alive on Dec 12th 45 192 , and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH * was as follows:

Myocardeleu

(Duration) yrs 3 mos ds.

Contributory Secondary

(Duration) yrs mos ds.

(Signed) George Franklin Miller M.D.

Dec 12th 1945 (Address) 1429-S-St NW

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Nash., Va. DATE OF BURIAL: 12/15, 1945

20 UNDERTAKER: John T. Stewart ADDRESS: 30 N St NE

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return 'Laborer,' "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia. Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *scpticaemia,*" "PUERPERAL *peritonitis,*" *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12581

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George's

City or town: Huntsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, institution, or street address where death occurred:

Sheriff Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Huntsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sheriff Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Ellen Green

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

8.(b) Name of husband or wife: Thomas Green

8.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): Feb 25, 1865

8. AGE:

Years	Months	Days	If less than one day
80	10	5	hrs. min.

9. Birthplace: Washington DC (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: Frank Weldon

FATHER — 13. Birthplace: Washington, D.C.

MOTHER — 14. Maiden name: Cornelia Spriggs

MOTHER — 15. Birthplace: Washington D.C.

18. Informant: Louise Green

Address: Huntsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 3 46 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Washington, D.C.

18. Funeral director: Robert G. McGuire

Address: 1820-9th St N W

19. Dec 31 1946 (Date rec'd by registrar) Amanda Dorsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 1945 at 4 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Shock	
Due to: Impersonal burns of body and extremities	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 12-30-45

Where did injury occur? Huntsville P.G. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Clothes caught fire Injured while at work

23. SIGNATURE: Deputy medical examiner James V. Lord M. D. or other

Address: Forestville Md Date signed: 12-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

12582

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. + 20 days

Hospital, institution, or street address where death occurred:
Leland Memorial Hosp.

How long in hospital or institution? 2 mos. + 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 621 D St., S.W., D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Clara Gross

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1872

8. AGE:	Years	Months	Days	If less than one day
	73	3	6	hrs. min.

9. Birthplace: D.C.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Retired

FATHER 12. Name: Theodore Gross

FATHER 13. Birthplace: Louisiana

MOTHER 14. Maiden name: Caroline Berg

MOTHER 15. Birthplace: Germany

16. Informant: Hospital Record

Address: Riverdale Md.

17. Interment (Burial, cremation, or removal. Which?) Date thereof 12-11-45 (month) (day) (year)

Cemetery or crematory: 3605 - 14 St. N.W.

Location: Washington, D.C.

18. Funeral director: Francis Grimm Lowes Co.

Address: Washington D.C.

19. Dec. 11 1945 James Lowes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-11 1945, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21, 1945, to Dec 11 1945 and that I last saw h[illegible] alive on Dec 11 1945.

	DURATION
Immediate cause of death: Bronchogenic Carcinoma	Undetermined
with Metastases to bone	6 Mo.
Due to: Carcinoma Liver	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: Metastases to spine and liver.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. W. Malin MD
M. D. or other

Address: Riverdale, Md Date signed 12-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

12583

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Maryland Manor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One Year

Hospital, Institution, or street address where death occurred:

4721 - Hudson Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Maryland Manor

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4724 Hudson Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Fred Robert Hanscom

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Elise Hanscom

6.(c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) April 11, 1915

8. AGE: Years	Months	Days	If less than one day
30			hrs. min.

9. Birthplace San Francisco, Calif.

(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business U. S. Govt

FATHER 12. Name Fred Robert Hanscom

13. Birthplace Maine

MOTHER 14. Maiden name Erickson

15. Birthplace Finland

16. Informant Elise Hanscom

Address Maryland Manor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 10 1945 (mouth) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director The S-H. Sims Co

Address 2901 - 14th St NW

19. 12-7- 1945 (Date rec'd by registrar) Thos. D. Giffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1945, at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy medical Examiner

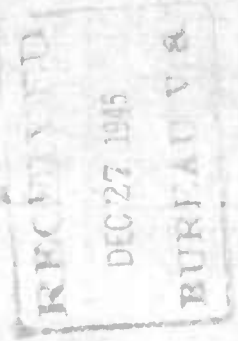
23. SIGNATURE James J. Boyd M. D. or other

Address Forestville Md Date signed 12-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



COPY SENT TO Co. Health officer DATE 12/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12584

Reg. Diat. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Glow Hill - Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Glow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7100 - Tucker Rd. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: OLIVA BEATRICE HAWKINS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: James A. Hawkins
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 27 - 1907

8. AGE: Years: 38 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Glow Hill - Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business: Home wife

FATHER
12. Name: Nelson E. Gant
13. Birthplace: Upper Marlbro - Md -

MOTHER
14. Maiden name: Eliza Morris
15. Birthplace: Glow Hill - Md

18. Informant: James A. Hawkins
Address: Glow Hill - Maryland -

17. Burial, cremation, or removal. Which?: Burial
Date thereof: 12-16-45 (month) (day) (year)
Cemetery or crematory: Glow Hill Cemetery
Location: Glow Hill - Maryland

18. Funeral director: Chas. S. Hines & Co -
Address: 901 - 3 St. S.W.

19. 12/13 1945 (Date rec'd by registrar)
Thos S Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 13 1945, at 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 1945, to Dec 13 1945
and that I last saw her alive on Dec 12 1945

Immediate cause of death	DURATION
Acute myocardial failure and Pulmonary edema	24 hrs
Due to: Cardio Vascular Renal Disease	4 Years
Due to: unknown	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operation: none
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: no Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul C. Van Hetta M. D.
Address: Washington D.C. Date signed: Dec 13 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (38a)

CERTIFICATE OF DEATH

12585

Reg. Dist. No. 234

1. PLACE OF DEATH:

County: Prince Georges

City or town: Laurel - Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~3~~ 3 days

Hospital, institution, or street address where death occurred:
307 Third Ave. St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: North Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles L. Hiett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(c) If alive, give age ..... years

B.(b) Name of husband or wife: Alice Hiett

7. Birth date of deceased (mo., day, yr.): Sept-12-1903

8. AGE:

Years	Months	Days	If less than one day
41	3	4	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business

FATHER
12. Name: James B Hiett
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Virginia Snowden
15. Birthplace: W. Va.

16. Informant: Boyd Hiett

Address: Laurel Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec-19-45 (month) (day) (year)

Cemetery or crematory: Ivy Hill

Location: Laurel Md

18. Funeral director: Lloyd Lasier

Address: Laurel Md.

19. December 19 1945 (Date rec'd by registrar) Cora E. Wachter Deputy. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16 1945 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 12 1945 to Dec 16 1945 and that I last saw him alive on Dec 16 1945

Immediate cause of death	DURATION
Broncho Pneumonia	3 days
Due to: Acute Nephritis	2 days
Due to: Influenza	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. M. Warren M.D.
M. D. or other

Address: Laurel Date signed 12/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

1258 245

Reg. Diat. No.

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Laland Memorial Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundell

City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Masons Beach
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Cora May Hoart

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	married

8.(b) Name of husband ~~of wife~~: Wilson Albert Hoart

7. Birth date of deceased (mo., day, yr.): Jan 10 — 1886 6.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day
59	10	22	hrs. min.

9. Birthplace: Williams port Penn (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Graduate nurse

FATHER — 12. Name: Thomas Monroe Stumpf

13. Birthplace: Penn.

MOTHER — 14. Maiden name: Mollie Mary Smith

15. Birthplace: Penn.

16. Informant: Wilson A. Hoart. Husband

Address: 7 Marlin Green. Bellaire Md. S.W.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12-8-45 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: W. W. Chambers Co

Address: 517-11th st. S.E.

19. Dec 8 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 7 1945, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 1945, to Dec 7 1945

and that I last saw h... alive on Dec 7 1945

Immediate cause of death: Carcinomatosis involving entire abdomen — DURATION: unknown

Due to: Primary Ca Ovarian undetermined

Due to: Primary carcinoma of intestines Cecum — Duration: Six months

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Inoperable carcinoma — Date of op. Oct 24 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry J. Hadley M. D. or other

Address: 1252 6th St Date signed Dec 7 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-F)

CERTIFICATE OF DEATH

1258

Reg. Dist. No. 240

1. PLACE OF DEATH:

County: Prince Georges

City or town: Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs

Hospital, Institution, or street address where death occurred: Auth Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Auth Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Martha Elizabeth Hoffman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles Hoffman

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 19, 1865

8. AGE: Years: 80 | Months: 9 | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Charles County, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: James T. Mattingly

FATHER — 13. Birthplace: St Mary's Co Md

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Charles Hoffman

Address: Camp Springs Md

17. Burial (Burial, cremation, or removal, which?) Date thereof: 12/22/45 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Forestville, Md

18. Funeral director: Hunt & Ryon

Address: Waldorf, Md.

19. 12-21-45 (Date rec'd by registrar) M. L. Moore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19 1945, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Exhaustion	
Due to Carcinoma of throat	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.: .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James T. Ford M. D. or other

Address: Forestville Md Date signed: 12-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of name of county of place of death is shown on FILM No. I 00 JAN 18 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-6)

CERTIFICATE OF DEATH

12588

Reg. Dist. No. 231

1. PLACE OF DEATH:
County ~~Landover, Md~~ Prince Georges
City or town Landover
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince Georges
City or town Landover Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William A. Hoffman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Helen C.
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19th 1894

8. AGE: Years	Months	Days	If less than one day
51			hrs. min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Mgr. Resturant
11. Industry or business
FATHER 12. Name John W. Hoffman
13. Birthplace Md
MOTHER 14. Maiden name Sadie Anderson
15. Birthplace Md
18. Informant Helen C. Hoffamn
Address Landover, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 24 -1945 (month) (day) (year)
Cemetery or crematory Arlington, Batl. Cem.
Location Arlington, Va.
18. Funeral director The S. H. Hines Co.,
Address 2901- 14th St. N. W.
19. 12/23 45 (Date rec'd by registrar) Amanda Deuney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1945 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 1944 to Dec 21 1945 and that I last saw him alive on Dec 21 1945

Immediate cause of death	DURATION
Congestive Heart Failure	10 hrs.
Due to Hypertensive Cardio-Vascular	5 yrs.
Due to Renal Disease	
Other conditions Arteriosclerosis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James C. Larson M. D. or other
Address Upper Marlboro, Md Date signed 12-21-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
DEC 28 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12589

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 8 days
Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 6 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1256- New Jersey Ave., N.W., Apt.#5 (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: RUBY HOLLOWAY

3.(b) Social Security Number: 578-03-7296

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married (separated

6.(b) Name of husband or wife: Edward Holloway
6.(c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): June 28, 1910

8. AGE: Years	Months	Days	If less than one day
35	5	21	...hrs. ...min.

9. Birthplace: Edgefield Co., So. Carolina (Town, county, and state)
10. Usual occupation: laundry worker
11. Industry or business: -

FATHER
12. Name: James Adams
13. Birthplace: ? South Carolina

MOTHER
14. Maiden name: Gertrude Harrison
15. Birthplace: ? So. Carolina

16. Informant: decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12 - 19 - 45 (month) (day) (year)
Cemetery or crematory: Removal to Wash. D.C.
Location:
18. Funeral director: John J. Flavin
Address: 300 A St N.E.

19. Dec. 19, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 19, 1945, at 4.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11, 1945, to Dec. 19 1945
and that I last saw her alive on Dec. 18, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 mo.
Due to Complication: Tuberculous laryngitis	3 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 12/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of name of county where death occurred is shown on FILM No. G 99 DEC 20 1945

12590

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: ~~Baltimore~~ Pr. Georges
City or town: Greendale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: 4604 21st St
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural - Greendale
(If rural, give LOCATION)
2.(o) If veteran, name war:

3.(a) FULL NAME: Cora Agnes Hunter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Chas. Chester Hunter
7. Birth date of deceased (mo., day, yr.): Dec 1, 1858 6.(c) If alive, give age: 87 years

8. AGE: Years: 87 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Rochester, N.Y. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Jefferson H. Knapp
13. Birthplace: Rochester, N.Y.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Rochester, N.Y.

16. Informant: Chas. H. Hunter
Address: 4604 21st St.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec 6, 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Md.

18. Funeral director: Abe S. H. King & Co
Address: 2901 14th St. N.W.

19. 12/6 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 6 1945, at 5 o'clock P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1943 19.. to Dec. 6 1945
and that I last saw her alive on Dec. 6 1945

	DURATION
Immediate cause of death: Old age	
Due to: Cerebral apoplexy	7 weeks
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank R. Shea M.D.
M. D. or other
Address: 4100 - 22nd St. N.E. Date signed: Dec 6, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24C)

CERTIFICATE OF DEATH

★ 12591 245

Reg. Dist. No.

1. PLACE OF DEATH:

County: Prince Georges

City or town: Mt. Rainier, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
3701 - Eastern Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 801-A St. S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Olympia F. Jenkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Mr. Lewis C. Jenkins

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 6, 1877

8. AGE: Years	Months	Days	If less than one day
68			hrs. min.

9. Birthplace: Bryantown, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: John T. Burch
13. Birthplace: Bryantown, Md.

MOTHER
14. Maiden name: Sarah Freeman
15. Birthplace: Bryantown, Md.

16. Informant: Lloyd L. Jenkins
Address: 3701 Eastern Ave. Mt. Rainier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 6 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland Rd. & D.C. Line

18. Funeral director: William J. Malley

Address: 3200 - R.I. Ave. Mt. Rainier, Md.

19. Dec 5 1945 (Date rec'd by registrar) James Selby Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4 1945, at 4:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 27 1945, to Dec. 1 1945 and that I last saw her alive on Dec. 1 1945

Immediate cause of death	DURATION
Toxemia	
Due to: Cirrhosis of Liver	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 4616 Argyle Terrace, N.W. Date signed: Dec. 5, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12592

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 13 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1436 Swann St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: CHARLES JOHNSON

3.(b) Social Security Number: 577-24-9131

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 17, 1908

8. AGE:	Years	Months	Days	If less than one day
	37	6	7	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business:

FATHER
12. Name: Henry Johnson
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Mary ?
15. Birthplace: Washington, D. C.

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) (day) (year) Dec 26, 1945

Cemetery or crematory:

Location: Washington, D C

18. Funeral director: Robert G. McGuire

Address: 1820-9th St N W.

19. (Date rec'd by registrar) Dec 24, 1945 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24, 1945 at 9.55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11, 1944 to Dec. 24, 1945 and that I last saw him alive on Dec. 24, 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	1 yr 8 mo.
with fatal hemorrhage	
Due to: of lung.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md Date signed: 12/24/45

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

12593 23 2

Reg. Dist. No.

1. PLACE OF DEATH:
County Prince George
City or town Forestville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pr. George
City or town Forestville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Buchanan Jones

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: widowed
6. (b) Name of husband or wife: Agnes Pollock
6. (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April 23 - 1856.
8. AGE: Years 89 Months 8 Days 8 If less than one day ..... hrs. ..... min.
9. Birthplace: Hall Station, Pr. Geo. Co., Md.
(Town, county, and state)
10. Usual occupation: Retired farmer.
11. Industry or business:
FATHER 12. Name: James Jones
13. Birthplace: Pr. Geo. Co., Md.
MOTHER 14. Maiden name: Margaret Warren
15. Birthplace: Pr. Geo. Co., Md.
16. Informant: Mrs. Bertie D. Chaney
Address: Forestville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-2-46. (month) (day) (year)
Cemetery or crematory: Trinity
Location: Upper Marlboro, Md.
18. Funeral director: Pierce Brothers
Address: Upper Marlboro, Md.
19. Jan 2 1946 (Date rec'd by registrar) R. Duvall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 31 1945, at 9.10 P.M.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Oct 1 1945, to Dec 31 1945, and that I last saw h... alive on Dec 31 1945.

Immediate cause of death	DURATION
Congestive Heart Failure	Month
Due to: Arteriosclerosis	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James E. Sasscer M. D. or other
Address: Upper Marlboro, Md. Date signed 1-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

12594

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County 730 - 60th Ave
City or town Fairmont Heights Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Fairmont Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 730 - 60th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Walter King

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
80		27	hrs. ..... min.

8. Birthplace Texas (Town, county, and state)
10. Usual occupation Interior decorator
11. Industry or business

FATHER
12. Name Walter King
13. Birthplace Texas

MOTHER
14. Maiden name Josephine Beavers
15. Birthplace Texas

16. Informant Wesley S King
Address 730 - 60th Ave.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12-30-45 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director Milton T. Mahan
Address 424 R-St N.W.

19. 12-30-45 (Date rec'd by registrar) Carrie J. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29 1945, at 10 1/2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1945, to Dec 29, 1945, and that I last saw h.[illegible] alive on Dec 28, 1945.

Immediate cause of death	DURATION
Uremia	3 days
Due to Hypertensive Cardio-Vascular and Renal Disease	2 years
Due to Essential Hypertension	?
Other conditions Generalized Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert R. Nelson MD
Address 417 Grant St. NE M. D. or other
Date signed 12/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

12595

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred: Prince Georges General

How long in hospital or institution? 38 hrs. 30 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5019 Edmonston Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Fannie Cathrine Kline

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife: B. F. Kline

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 28, 1879

8. AGE: Years	Months	Days	If less than one day
66			..... hrs. ..... min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Glen Spitzer
13. Birthplace: Va.

MOTHER
14. Maiden name: Sarah Gulliday
15. Birthplace: Va.

16. Informant: Mr. E. M. Shaw
Address: 706 A-St. N.E. Wash. D.C.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 12/29/45
(month) (day) (year)
Cemetery or crematory: Baker & Sons Funeral Co
Location: Manassas Va

18. Funeral director: L Gracie Sons
Address: Hyattsville Md.

19. 12/29 19 45 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-29 19 45, at 12 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-26 19 45, to 12-29 19 45.
and that I last saw her alive on 12-29- 19 45

Immediate cause of death: Diabetes mellitus	DURATION
Due to: ?	
Due to: ?	
Other conditions: Diabetic ulcers leg	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John M Brennan M. D. or other

Address: Prince Geo. Gen Hosp Date signed 12-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

1259 42

Reg. Diat. No. 234

1. PLACE OF DEATH:

County: Prince Georges Co.

City or town: Bladensburg Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr. Geo Co.

City or town: Bladensburg Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2704 - 49th Ave N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Dora V. Landon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James T. Landon

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov - 11th. 1878

8. AGE: Years: 67 Months: Days: If less than one day: hrs. min.

9. Birthplace: Columbus Ohio (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Simeon Garrett

13. Birthplace: Ohio

MOTHER 14. Maiden name: Mary Creamer

15. Birthplace: Maryland

16. Informant: Olive M. Landon Daughter

Address: 2704 - 49th Ave Bladensburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 19 - 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Suitland Maryland

16. Funeral director: Thomas F. Murray

Address: 2007 Nicholson St. Hyatts.

19. Dec 17 1945 (Date rec'd by registrar) Howard I. Beall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 17 1945, at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2 1945 to Dec. 16 1945 and that I last saw h.e.r. alive on Dec. 15 1945

Immediate cause of death	DURATION
Carcinoma of uterus & cervix	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Olive M. Landon M. D. or other

Address: 2015 Nicholson St. Date signed: 12/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12597

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1440 Wisconsin Avenue N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: H. EM LEE

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Chinese	Widowed

6.(b) Name of husband or wife: Long See

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): February 10, 1868

8. AGE:	Years	Months	Days	If less than one day
	77	10	9	...hrs. ...min.

9. Birthplace: San Francisco, California
(Town, county, and state)

10. Usual occupation: Laundry

11. Industry or business:

FATHER
12. Name: How Dog Lee
13. Birthplace: China

MOTHER
14. Maiden name: Gee Chee
15. Birthplace: China

16. Informant: Fon Lee (son)
Address: 1440 Wisconsin Avenue N. W.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 12 - 24 -45 (month) (day) (year)

Cemetery or crematory: FORT LINCOLN CEMETERY

Location: WASHINGTON D.C.

18. Funeral director: J. William Lee & Sons.

Address: 360 7th st N.E.

19. Dec. 20 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 19 1945, at 12.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 17 1945 to Dec 19 1945 and that I last saw him alive on Dec 19 1945

Immediate cause of death	DURATION
Duodenal ulcers with fatal hemorrhage	1 mo
Due to Complications of Pulmonary tuberculosis	1 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Duodenal ulcers with rupture

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Intestinal tract below, filled with blood. Tuberculous spitting / right or left

Accident, suicide, or homicide / Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed 12/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

12598

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Prince Georges
City or town: Bettsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges.
City or town: Bettsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 137 Garrett ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles H. Leizear

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: x x x

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 13th 1883

8. AGE:

Years	Months	Days	If less than one day
62	7	7	..... hrs. ..... min.

9. Birthplace: Prince George . Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: John Leizear
13. Birthplace: Md.
MOTHER 14. Maiden name: Harriett Leizear
15. Birthplace: Md.
16. Informant: Mrs Blanch Flora
Address: Bettsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 24 1945 (month) (day) (year)
Cemetery or crematory: Calesville Cemetery
Location: Calesville. Md
18. Funeral director: H. H. Chambers Co.
Address: Riverdale, Md.
19. Dec 21 19 45 James Seley Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-20 1945 at 4:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 1 1942 to 12 20 1945
and that I last saw him alive on 12 18 1945
Immediate cause of death: Cort Cerebral Hemorrhage — DURATION: 12 20 45
Due to: Diabetes Mellitus — 1940
Due to: Hypertension — 1940
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B P Warren M. D. or other
Address: Laurel Md Date signed 12 20 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on . .

STATE OF MARYLAND—CERTIFICATE OF DEATH

FILED JUN 11 1946

12599 240

92-P

1. PLACE OF DEATH

County Prince Georges — Registration Dist. No. 105

Village or City Brandywine, Md. No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. 6 mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Clarence Milton Magness

(a) Residence: No. ____ St., ____ Ward. ____

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	white	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Ann Magness

6. DATE OF BIRTH (month, day, and year): Aug 20 1878

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
67	6-8-	4	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Carpenter

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: ____

10. Date deceased last worked at this occupation (month and year): Dec. 1940

11. Total time (years) spent in this occupation: 30 yrs

12. BIRTHPLACE (city or town) (State or country): Jarrettsville, Md

FATHER

13. NAME: John Milton Magness

14. BIRTHPLACE (city or town) (State or country): Rocks, Md

MOTHER

15. MAIDEN NAME: Carmen

16. BIRTHPLACE (city or town) (State or country): Rocks, Md

17. INFORMANT (Address): Edith Ann Magness, Brandywine, Md

18. BURIAL, ~~CREMATION, OR REMOVAL~~: Place Coop Town, Md. Date 1/2, 1946

19. UNDERTAKER (Address): Hunter & Ryon, Waldorf, Md.

20. FILED 12-31, 19 45 — H. M. Mosher, Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Dec (Month) 29 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Oct 15 1945, to Dec 29, 1945

I last saw him alive on Dec 27, 1945; death is said to have occurred on the date stated above, at 11:30 P. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	12/27/45
Other **Contributory Causes** of importance:	
Mitral Regurgitation	24 yrs

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? ____

If so, specify ____

(Signed) John E. Powers, M. D.

(Address) Brandywine, Md

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-C

CERTIFICATE OF DEATH

12600

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George's
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
RFD #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD # 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Singleton Aubrey Marcus

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ernie C. Marcus
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Oct. 17th 1904.

8. AGE: Years	Months	Days	If less than one day
41	2m	13	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: John C. Marcus
13. Birthplace: Va.

MOTHER
14. Maiden name: Alberta Tiernery
15. Birthplace: Va.

16. Informant: Junella Green
Address: RFD. # 1, Hyattsville, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 1-2-46 (month) (day) (year)
Cemetery or crematory: Geo. Wash. Cemetery
Location: Hyattsville, Md.

18. Funeral director: Wm Chambers & Son
Address: Riverdale, Md.

19. Jan 2 1946 (Date rec'd by registrar) James Lacey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30, 1945 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to: Acute Alcoholism	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other
Address: Forestville, Md. Date signed 12/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12601

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or Institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 421 L. St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: MARTIN, BAKER

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	married

6.(b) Name of husband or wife: Emma Baker

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 23, 1895

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
50	4	21		

9. Birthplace: Penn. County, Virginia
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business:

FATHER — 12. Name: Washington, Martin

13. Birthplace: Madison, Virginia

MOTHER — 14. Maiden name: Lelia Martin

15. Birthplace: Virginia

16. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 15. 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: D F Doherty - Home St. Joseph Funeral Home

Address: 306 L. St N.W.

19. Dec 15 1945 (Date rec'd by registrar) Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 14 19 45 at 6 00 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10, 1945 to Dec. 14 1945 and that I last saw him alive on Dec. 14, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4½ mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 12/14/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12602

Reg. Diat. No. 243.

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs., 1 mo., 4 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 yrs., 1 mo., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 239 - 10th St. S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LOUISE MATHEWS

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: –

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 1, 1916

8. AGE: Years	Months	Days	If less than one day
29	11	19	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Card-punch Operator

11. Industry or business:

FATHER — 12. Name: Thomas Tolson

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Myrtle Duckett

15. Birthplace: Maryland

16. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 20, 1945 (month) (day) (year)

Cemetery or crematory: Washington

Location: D. C.

18. Funeral director: W. Earl Bettes

Address: 1203 Walter St. S.E.

19. Dec. 20, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 20 1945, at 2:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOVEMBER 16 1945, to DECEMBER 20 1945

and that I last saw h... alive on DEC. 19 1945

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	3 yrs 1 mo
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 12/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth of deceased is shown on FILM No. 100 FEB 1 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48a)

CERTIFICATE OF DEATH

12613

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Bradbury Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Bradbury Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5115 W st. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lottie F. Mc Cann

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: ~~XXXX~~ Paul P. McCann
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 8, ~~1886~~ 1885

8. AGE: Years: 69 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: William Partlow
13. Birthplace: Virginia

MOTHER
14. Maiden name: Florence Purcell
15. Birthplace: Virginia

16. Informant: Paul P. McCann
Address: 5115 W. st. S. E.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 20 1945 (month) (day) (year)
Cemetery or crematory: Ivy Hill Cemetery
Location: Alexandria, Va.
18. Funeral director: J. Williams Leis Sons Co
Address: 300 - 4 st NE Wash. D.C.
19. 12/18 19 45 Thos D Griffith (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17, 1945 at 10 45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 45 to Dec 17 19 45 and that I last saw her alive on Dec 16 19 45

Immediate cause of death	DURATION
Carcinoma of Cervix	6 mo.
Due to: —	
Due to: —	
Other conditions: None of note	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Non
Accident, suicide, or homicide: — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Thos C. Van Natta M. D. or other
Address: Washington D.C. Date signed: Dec 18 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12604

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Diat. No. 231

M

I

T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution? dead on arrival.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Mt. Ranier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3812 - 33rd. St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jessie Sime McLeish

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	W	widowed

6.(b) Name of husband or wife: John P. McLeish. dead.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Dec 31 1876

8. AGE: Years	Months	Days	If less than one day
69			..... hrs. ..... min.

9. Birthplace: Dundee, Scotland. (Town, county, and state)
10. Usual occupation: Home maker.
11. Industry or business

FATHER
12. Name: ? Sime
13. Birthplace: Scotland.

MOTHER
14. Maiden name: Unknown.
15. Birthplace: Scotland.

16. Informant: Miss Nellie McLeish.
Address: 3812 33rd St. Mt. Ranier, Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Dec. 22, 1945 (mouth) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Prince George Cy. Md.
18. Funeral director: W. W. Chamberlin.
Address: Riverdale, Md.
19. 12/21 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20, 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 20, 1945, to Dec. 20, 1945
and that I last saw her alive on December 20, 1945

Immediate cause of death	DURATION
Bronchopneumonia	3 days.
Due to	
Due to Chr. Bronchitis	1 year
Other conditions Generalized Arteriosclerosis	Sev. months.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Mt Ranier Md. Date signed 12/20/45

12605

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 Yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3833-34th St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GAETANO MICALIZZI

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Carmela
7. Birth date of deceased (mo., day, yr.): January 29, 1887 6.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace: Italy (Town, county, and state)
10. Usual occupation: Barber
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Italy

MOTHER
14. Maiden name: Unknown
15. Birthplace: Italy

16. Informant: Frank J. Micalizzi
Address: 5024 - Illinois Ave. N.W. Wash. D.C.,
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 29. 1945 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.
18. Funeral director: William J. Malley
Address: 3200-R.I. Ave. Mt. Rainier, Md.
19. Dec. 28" 1945 James Sevey (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26 1945, at 11 30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 11 1945, to Dec. 26 1945
and that I last saw h... alive on Dec. 26 1945

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to: Cardio Renal Vascular	5 yr.
Due to:	
Other conditions: Arthritis	6 yr.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wm H. Norton M.D. (M. D. or other)
Address: 3837-34 St. Date signed: 12-27-45
Mt Rainier Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

12606

CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS OF

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince Geo
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo
City or town: 121 Second St.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lillie C. Miller

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Frank W. Miller
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 21 - 1888

8. AGE: Years	Months	Days	If less than one day
57	9	16	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
12. Name of FATHER: Francis Yeoman
13. Birthplace of FATHER: Md.
14. Maiden name of MOTHER: Annie L. DeBoy
15. Birthplace of MOTHER: Md
16. Informant: Miss Emma Miller
Address: Laurel
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 12-45 (month) (day) (year)
Cemetery or crematory: St Marys
Location: Laurel
18. Funeral director: Lloyd Kaiser
Address: Laurel Md
19. December 11, 1945 (Date rec'd by registrar) Carl E. Wachter Registrar
Deputy.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 9 1945, at 1:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 1945 to Dec 9 1945
and that I last saw h... alive on Dec 8 1945

Immediate cause of death	DURATION
Chronic Interstitial nephritis - Mitral	1 yr
Due to: Pregnancy	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W B Leonard (M.D. or other)
Address: Laurel Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12607

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos., 18 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 8 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1223- 13th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Thomas Moore

3.(b) Social Security Number: 578-09-5249

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 19, 1908

8. AGE: Years	Months	Days	If less than one day
37	3	2	hrs. min.

9. Birthplace: Fairfax Co., Virginia (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business:

FATHER
12. Name: Edward Moore
13. Birthplace: Fairfax Co., Virginia

MOTHER
14. Maiden name: Alice Morris
15. Birthplace: Fairfax Co., Virginia

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12/21/45 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: D. S. Saffell
Address: 495 H N W

19. Dec. 21, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21, 1945, at 6:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3, 1945, to Dec. 21, 1945 and that I last saw h.. l.. alive on Dec. 21, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	9 mo.
Due to: Tuberculous Enteritis	2 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: Dec. 21, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

12608

Reg. Dist. No. 2032

1. PLACE OF DEATH:

County Prince George's

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince George's County Jail

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Allen Mullikin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 - 1903.

8. AGE: Years 42 | Months 5 | Days 22 | If less than one day hrs. min.

9. Birthplace Upper Marlboro, Md.
(Town, county, and state)

10. Usual occupation Farm Laborer

11. Industry or business

FATHER 12. Name Owen Pinkney Mullikin

13. Birthplace Pr. Geo. Co., Md.

MOTHER 14. Maiden name Mary Ann Wells

15. Birthplace Upper Marlboro, Md.

16. Informant John C. Mullikin

Address 260 Wash. Blvd. Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-24-45 (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Upper Marlboro, Md.

18. Funeral director Pilchie Bros.

Address Upper Marlboro, Md.

19. Dec 23 1945 (Date rec'd by registrar) Earl Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardiac infarction	
Due to	
Due to	
Other conditions Cirrhosis of the liver	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE James I. Ford M. D. or other

Address Forestville, Md. Date signed 12-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15 (M) MARGIN RESERVED FOR BINDING (I) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-a)

CERTIFICATE OF DEATH

12609

★ Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges.
City or town Riverdale.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Monty.
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. U.S. 20 Fair Field Drive.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Rose Mulvihill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife James Simon Mulvihill
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) March 18, 1890

8. AGE: Years	Months	Days	If less than one day
55	8	16	..... hrs. ..... min.

9. Birthplace Austria (Town, county, and state)
10. Usual occupation housewife
11. Industry or business own home.
12. FATHER Name Michael Gnip
13. Birthplace Austria
14. MOTHER Maiden name Anna ?
15. Birthplace Austria
16. Informant Leland Memorial Hosp. Records
Address Riverdale, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 6. 1945 (month) (day) (year)
Cemetery or crematory Mt Olivet Cemt.
Location Washington DC
18. Funeral director Albert H. Rabe
Address 641 - 14th St N.E. Washington
19. Dec 4 19 45 James Berry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1945, at 6.30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1945 to Dec 4 1945
and that I last saw her alive on Nov 30 1945

Immediate cause of death	DURATION
Heart failure	
Due to Cardio-vascular	
Due to renal disease	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Sidney W. Lowery M.D. or other
Address 4404 Queenstown Rd. Rod. Md. Date signed 4 Dec 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12610

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County: Washington
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2005 L. Street N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Broadus ~~Mango~~ Mungo

3.(b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary Mungo
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): May 14, 1896

8. AGE: Years	Months	Days	If less than one day
49	6	24	....hrs. ....min.

9. Birthplace: South Carolina
(Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business

FATHER
12. Name: Louis Mungo
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Margaret Blackmey
15. Birthplace: South Carolina

16. Informant: Decedent
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof 12-9-45 (month) (day) (year)
Cemetery or crematory: —
Location: Washington, D.C.
18. Funeral director: Boyd.
Address: 1238 - 20 St N.

19. Dec. 8, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8 1945, at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1945, to Dec 8 1945
and that I last saw h.. alive on Dec 8 1945

	DURATION
Immediate cause of death: Tuberculosis of Lungs	11 yrs
Due to: Lung Abscess	1 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed 12-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12611

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3814-33rd St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie E. Murdock

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: David B. Murdock
6.(c) If alive, give age: 87 years

7. Birth date of deceased (mo., day, yr.): Feb. 20th 1863

8. AGE: Years	Months	Days	If less than one day
82			hrs. min.

9. Birthplace: Washington D. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER — 12. Name: James Williams
13. Birthplace: Ireland
MOTHER — 14. Maiden name: Botchford
15. Birthplace: Unknown
16. Informant: Grace L. Long
Address: 3814-33rd St. Mt. Rainier Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 18th 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Maryland
18. Funeral director: Wm. J. Malloy
Address: 3200 R.I. Ave. Mt. Rainier Md.
19. Dec 18 1945 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16, 1945, at 4:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 14, 1945, to December 15, 1945
and that I last saw her alive on December 15, 1945

Immediate cause of death	DURATION
Bronchopneumonia	Dec. days
Due to	
Due to	
Other conditions: Generalized arteriosclerosis	1 year

(Incinde pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please nuderline the cause to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Mt Rainier, Md. Date signed: 12/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-c)

CERTIFICATE OF DEATH

12612

★ Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Brookeville Manor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Nameless

Hospital, Institution, or street address where death occurred:

Ager Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 633 - 12th N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Bobby Dean Newton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 28, 1926

8. AGE: Years: 19 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Hickory North Carolina (Town, county, and state)

10. Usual occupation: Corporal

11. Industry or business: Army of the United States.

FATHER 12. Name: Henry C. Newton

13. Birthplace: N. Car.

MOTHER 14. Maiden name: May E. Abernathy

15. Birthplace: N. Car.

16. Informant: Henry C. Newton

Address: 633 12th st N.E. Wash D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec 3, 1945 (month) (day) (year)

Cemetery or crematory: S.W. Hines Funeral Co.

Location: 14th & Harvard sts N.W. Washington D.C.

18. Funeral director: F. Rascia & Son

Address: Hyattsville Md.

19. December 3, 19 45 James Severs

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2, 19 45, at 8 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage Shock	
Due to: Crushed Chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 12-2-45

Where did injury occur? Brookeville Manor P.G. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Ager Road

Means of injury: I saw that he injured at work?

Motor vehicle accident

23. SIGNATURE: Clarence T. Ford M. D. or other

Address: Forestville Md. Date signed: 12-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12613

CERTIFICATE OF DEATH

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3009 Rodman St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: John W. Nickles

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lillie Eiker (dec.)

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 7, 1859

8. AGE: Years	Months	Days	If less than one day
86	6	22	hrs. min.

9. Birthplace: Cincinatti, Ohio
(Town, county, and state)

10. Usual occupation: Bibliographer of Geology

11. Industry or business: –

FATHER
12. Name: Samuel Nickles
13. Birthplace: Cincinatti, Ohio

MOTHER
14. Maiden name: Alice Velmer
15. Birthplace: Germany

16. Informant: Decedent
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12/29/45 (month) (day) (year)

Cemetery or crematory:

Location: Wash. D. C.

18. Funeral director: Martin F. Tyrony Co

Address: 1300 N. St. N.W. Wash. D.C.

19. Dec. 29, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29, 1945 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 6, 1945, to Dec. 29, 1945 and that I last saw h... alive on Dec. 29, 1945

	DURATION
Immediate cause of death: Pulmonary tuberculosis	3 yrs 4 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: Dec. 29, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10-E)

CERTIFICATE OF DEATH

12614

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: River Dale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hr 45 minutes
Hospital, institution, or street address where death occurred:
Leland Memorial
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1337-C St. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Joseph Raymond Norris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 19, 1925.

8. AGE: Years: 20 | Months: 0 | Days: 13 | If less than one day: hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business:

FATHER
12. Name: Francis Virgil Norris
13. Birthplace: Md.

MOTHER
14. Maiden name: Jane E. Raley
15. Birthplace: Md

16. Informant: Francis V. Norris
Address: 1337 C st N.E Washington D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec 3, 1945. (month) (day) (year)

Cemetery or crematory: S. H. Hines Funeral Co
Location: 14th & Harvard st N.W. Washington D.C.

18. Funeral director: E. Gaeke sons
Address: Hyattsville Md.

19. Dec 3 (Date rec'd by registrar) 19 45 James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 19 45, at 10 32 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Fractures of skull.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of? 12-2-45
Where did injury occur? Brookside Manor P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Ager Road
Means of injury: Passenger in Car Injured at work? No

Deputy medical Examiner
23. SIGNATURE: James W. Bond M. D. or other
Address: Hyattsville Md Date signed: 12-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

12615 P

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Prince George's
City or town Laurel - Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred: Hospital - 307 Pa. Ave. Ext.
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main St. - Rural
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Mary L. Osborn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John R. Osborn
6.(c) If alive, age ..... years

7. Birth date of deceased (mo., day, yr.) April 8th about 1869

8. AGE: Years	Months	Days	If less than one day
about 76	8	13	..... hrs. ..... min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business Self
FATHER 12. Name Samuel Shuman
13. Birthplace Pa.
MOTHER 14. Maiden name Sophia E. Palick
15. Birthplace Pa.
16. Informant Mrs Beatrice Vickers
Address Main St. - Laurel Md
17. Burial Date thereof 12/25/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory London Park
Location Balto. Md.
18. Funeral director William Cook Inc.
Address 1217 St. Paul St.
19. 12/22 19 45 AW Hebrank adk Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 19 45 at 1:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 1945 to Dec 21 1945 and that I last saw h.. alive on Dec 21 1945

Immediate cause of death	DURATION
Diabetes Mellitus	10 yrs
Myocarditis	
Due to	
Due to	
Other conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. M. Warren M.D.
M. D. or other
Address Laurel Date signed 12/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43)

CERTIFICATE OF DEATH

12616

Reg. Diat. No. 248

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hrs 20 min

Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital

How long in hospital or institution? 24 hrs 10 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Colmar Manor, Brentwood
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4318 Lawrence Street.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha Ann. Peachey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	infant

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 16, 1945

8. AGE: Years | Months | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Riverdale Prince Georges, Maryland.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John H. Peachey

FATHER 13. Birthplace Belleville Penna.

MOTHER 14. Maiden name Esther Horst.

MOTHER 15. Birthplace Clear Spring, Maryland.

16. Informant Mr. John H. Peachey

Address Colmar Manor Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 18, 1945 (month) (day) (year)

Cemetery or crematory Hagerstown

Location Maryland

18. Funeral director F Gaschi Sons

Address Hyattsville Md

19. Dec 17 1945 (Date rec'd by registrar) James Severy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945, at 6 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 16 1945 to Dec 17 1945; and that I last saw h.. alive on Dec 17 1945.

	DURATION
Immediate cause of death Death within 48 hours	
Due to Atelectasis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Congenital atelectasis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L.W. Mahon M.D
M. D. or other

Address Riverdale, Md Date signed 12-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2436 Cert. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 20 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1208- Eye St. S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: BENJAMIN EDWARD PIER

3.(b) Social Security Number: 578-12-7122

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruby B. Pier

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): February 24, 1884

8. AGE:

Years	Months	Days	If less than one day
61	10	–	...hrs. ...min.

9. Birthplace: Charleston, West Virginia
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER — 12. Name: Perry W. Pier

13. Birthplace: Charleston, West Virginia

MOTHER — 14. Maiden name: Mary Griffiths

15. Birthplace: Charleston, West Virginia

16. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 12-24-45 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D. C.

18. Funeral director: W. W. Chambers Co

Address: 5-17-11th St. S. E.

19. Dec. 24, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24th 1945, at 6 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4th 1945, to Dec 24th 1945, and that I last saw him alive on Dec 24th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M. D. or other

Address: Glenn Dale, Md. Date signed: 12/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS (A15)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

12618 Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County P. Geo.
City or town near Bowie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County P. Geo.
City or town near Mitchellville
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Ernestine Elizabeth Poula

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ Frank J. Poula deceased
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) March 28, 1858

8. AGE:

Years	Months	Days	If less than one day
87	8	7	— hrs. — min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation House work
11. Industry or business House work

FATHER
12. Name August Rochlitz
13. Birthplace Germany

MOTHER
14. Maiden name unknown
15. Birthplace

16. Informant Mrs Walter Stewart
Address Mitchellville Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec 8 1945 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Belair Road Baltimore Md
18. Funeral director Clarence Forcace
Address Mitchellville Md.
19. Dec 7 1945 Louise Z. Peach
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1945, at 8:15 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3, 1945, to Dec 5 1945
and that I last saw h e alive on Dec. 5 1945

Immediate cause of death	DURATION
Coronary Occlusion	
Arterio Sclerosis	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE G. Lancaster M.D.
M. D. or other
Address Bowie Md Date signed 12/5/45

12619

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 mos., 21 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 11 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1235 - 9th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3. (a) FULL NAME: Theodore RAINES

3. (b) Social Security Number: 579-12-392

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): December 8, 1915

8. AGE: Years	Months	Days	If less than one day
29	11	26	____ hrs. ____ min.

9. Birthplace: Philadelphia, Pennsylvania
(Town, county, and state)

10. Usual occupation: Presser

11. Industry or business:

FATHER
12. Name: Richard Raines
13. Birthplace: Philadelphia, Pennsylvania

MOTHER
14. Maiden name: Cora Price
15. Birthplace: Philadelphia, Pennsylvania

16. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 12/11/45 (month) (day) (year)

Cemetery or crematory:

Location: District Morgue, Washington DC

18. Funeral director:

Address:

19. Dec. 4, 1945 Rowland S. Plitt
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4, 1945, at 9:11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/13/1944 to 12/4/1945 and that I last saw h. alive on 12/4/1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	27 Mo
Due to: Syphilis	27 Mo
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 12/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12620

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 836

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, Institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Brandywine
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Richards, Charles Cleveland

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Mary O. Richards
deceased 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Feb. 26, 1886

8. AGE: Years	Months	Days	If less than one day
59	9	11	— hrs. — min.

9. Birthplace: Westwood, Prince Georges County, Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: —

FATHER
12. Name: Joseph Richards
13. Birthplace: Westwood, Md.

MOTHER
14. Maiden name: Margaret Eliz. Goldsmith
15. Birthplace: Prince Georges Co., Md.

16. Informant: Mrs. Margaret Gertrude Richards
Address: Westwood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-6-45 (month) (day) (year)

Cemetery or crematory: Fairmount
Location: Forestead, Md.

18. Funeral director: Pitcher Bros
Address: Upper Marlboro, Md.

19. Dec 6 45 James Devers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 6, 1945 at 7 13 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19, 1945 to Dec 6, 1945
and that I last saw him alive on Dec 6, 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	18 days
Due to: General arteriosclerosis	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L. W. Mudd M.D.
M. D. or other
Address: Riverdale, Md. Date signed 12-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

12621

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Bladensburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred: Depot 7 4517 - Baltimore Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Bladensburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4517 - Baltimore Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Ulrich Ridgeway

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

6.(b) Name of husband or wife: Carrie E. Ridgeway

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 7, 1880

8. AGE: Years	Months	Days	If less than one day
65	9	16	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Semi-retired laborer

11. Industry or business

FATHER 12. Name: Randolph Ridgeway

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Virginia

16. Informant: Helen Ridgeway Moore

Address: Burke, Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 27, 1945 (month) (day) (year)

Cemetery or crematory: ~~Glenn Dale Memorial Park~~ Evergreen Cemetery

Location: ~~Bladensburg, Md.~~ Bladensburg, Md.

18. Funeral director: F. Haugh's Sons

Address: Hyattsville, Md.

19. 12/26/45 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1945 at 12 56 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Deputy medical Examiner Edmund C. Ford M. D. or other

Address: Forestville Md Date signed: 12-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1262231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2103 Cheverly, Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Helen Virginia Sanchez

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Michael
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 11, 1923.

8. AGE: Years	Months	Days	If less than one day
22			..... hrs. ..... min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Leroy M Bosvree
13. Birthplace: Washington D.C.
MOTHER 14. Maiden name: Beulah M Bosvree
15. Birthplace: Washington D.C.
16. Informant: Beulah M Bosvree
Address: 2103 Cheverly ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 18, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetary
Location:
18. Funeral director: Albert J Ashe
Address: 641 H St. N.E.
19. 12/14/45 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 14 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 1945, to 1945
and that I last saw her alive on Dec. 13 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 /
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Louis H. Jinal M.D
M. D. or other
Address: Cottage City, Md. Date signed 12-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Sanchez.

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

12623

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince George Gen. Hosp
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 days
Hospital, Institution, or street address where death occurred:
Prince George General Hosp
How long in hospital or Institution? 32 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James. S. Sasscer.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	

6.(b) Name of husband or wife Mary Wilson
6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) July 28- 872

8. AGE: Years	Months	Days	If less than one day
73	5	4	hrs. min.

8. Birthplace md.
(Town, county, and state)
10. Usual occupation secretary
11. Industry or business

FATHER
12. Name Frederick Sasscer
13. Birthplace md.

MOTHER
14. Maiden name Rosalie Ghislen
15. Birthplace md.

16. Informant Frederick Sasscer.
Address 4230-34th St. Mt Rainier md.

17. Burial (Burial, cremation, or removal—which?) Date thereof 12-7-45. (month) (day) (year)
Cemetery or crematory Trinity Episcopal
Location Upper Marlboro, Md.

18. Funeral director Ritchie Brothers
Address Upper Marlboro Md.

19. 12/6 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12- 4 1945 at 2.10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4 1945 to Dec 4 1945
and that I last saw h-im alive on Dec. 4 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 months
Due to	
Due to	
Other conditions Paralysis Laryngo	2 wks.

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James S. Sasscer M. D. or other
Address Upper Marlboro Md Date signed 12-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

12624

Reg. Dist. No. 142

1. PLACE OF DEATH:

County: Prince George

City or town: Brandywine
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Ges.

City or town: Brandywine
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: FREDERICK SCHLAEFLI

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

8.(b) Name of husband or wife: Marie E. Schlaefli

7. Birth date of deceased (mo., day, yr.): April 11 1861 6.(c) If alive, give age ..... years

8. AGE: Years: 84 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Switzerland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: none

FATHER
12. Name: Jakob Schlaefli
13. Birthplace: Switzerland

MOTHER
14. Maiden name: Katherine Baumgartner
15. Birthplace: Switzerland

18. Informant: Emma Schlaefli
Address: Brandywine Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-19-45 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland, Md.

18. Funeral director: W. W. Chambers Co.

Address: 517 11th St S.E.

19. 12-17 (Date rec'd by registrar) 1945 Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 17 1945, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1945 to Dec 17 1945 and that I last saw h[illegible] alive on Dec 16 1945

Immediate cause of death	DURATION
Chronic Myocarditis	1 Year
Due to: Arteriosclerosis	Fatal
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John E Bowers M.D.
M. D. or other

Address: Brandywine Md. Date signed 12/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

12625

★ Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges

City or town Cheverly, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Prince Georges General Hospt.

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince Geo.

City or town Capital Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 438-59th Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Schlatter Mr. Peter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of ~~husband or~~ wife NANette Schlatter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7 1863

8. AGE: Years	Months	Days	If less than one day
82	5	10	....hrs. ....min.

9. Birthplace Austria (Town, county, and state)

10. Usual occupation Baker & Night Watchman

11. Industry or business Lucketa Lunch room

FATHER 12. Name Frank Schlatter

13. Birthplace Austria

MOTHER 14. Maiden name Philomenia Schlatter

15. Birthplace Austria

16. Informant NANette Schlatter (Wife)

Address 438-59th Ave, Cap. Hts, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-20-45 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland Md.

18. Funeral director W. S. Chambers Co

Address 517 11th St S.E.

19. 12/17/45 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17 1945 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 17 1945 to Dec 17 1945 and that I last saw him alive on Dec 17 1945

Immediate cause of death	DURATION
Congestive heart failure	1 week
Due to Arteriosclerotic heart disease	unknown
Due to	
Other conditions Carcinoma 2 rectum	unknown

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. M. Youngman M. D. or other

Address Prince Geo Gen Hosp Hosp Date signed 12-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12628

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Upper Marlboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Temporary

Hospital, Institution, or street address where death occurred:

Crane Highway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3419 Virginia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Joseph Leo Shanahan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Catherine C Shanahan 6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): Dec 2, 1918

8. AGE:

Years	Months	Days	If less than one day
27	1	22	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Seaman 1/c

11. Industry or business: U.S. Navy

FATHER 12. Name: Joseph Leo Shanahan

FATHER 13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Nellie Hardenbrook

MOTHER 15. Birthplace: Baltimore, Md

18. Informant: Tommy Byers

Address: 5005 Park Heights, Balto, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12/25/45 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Baltimore, Md.

18. Funeral director: Geo. W. Kise & Son

Address: 2900 M St N.W. Wash. D.C.

19. 12/25 19 45 Arnold Dawson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24 19 45, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Hemorrhage Shock	
Due to: Fracture Fskull Crushed Chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 12-24-45

Where did injury occur? Upper Marlboro Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? Crane Highway

Means of injury: Car ran off Road Injured at work? No

23. SIGNATURE: Deputy Medical Examiner M. D. or other

Address: Forestville Md Date signed: 12-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-0)

CERTIFICATE OF DEATH

12629

Reg. Diat. No. 232

1. PLACE OF DEATH:

County: Prince Georges

City or town: Oak Grove

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 years

Hospital, institution, or street address where death occurred:

Largo Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Oak Grove

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Largo Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Cecelie Sharpes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

8.(b) Name of husband or wife: Paul Sharpes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1860

8. AGE: Years: 85 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: John Evans

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Rachel

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Lee Hyken

Address: Oak Grove, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 3 1946 (month) (day) (year)

Cemetery or crematory: Mt Nebo

Location: Prince George Co.

18. Funeral director: J. B. Johnson

Address: Upper Marlboro

19. Jan 3rd 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 1945 at 4.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1944 to Dec 29 1945

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Uremia	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James A. Boyd M. D. or other

Address: Forestville Md Date signed: 1-29-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

12627

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred: 6500 - 44th Ave.
How long in hospital or institution? 1 mo

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)
Street No. 6500 - 44th Ave. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Barnett Sherman

3.(b) Social Security Number: 220-12-3051

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Tillie
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): April 5, 1887

8. AGE: Years: 58 | Months: 8 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Tailor
11. Industry or business: Clothing

FATHER
12. Name: Isaac
13. Birthplace: Russia

MOTHER
14. Maiden name: Rose
15. Birthplace: Russia

16. Informant: Shirley Fliss
Address: 6500 - 44th Ave. Hyattsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 17, 1945 (month) (day) (year)
Cemetery or crematory: Adath Israel Cem.
Location: Gorman Mill Rd. Baltimore, Md.

18. Funeral director: Jack Lewis
Address: 1441 E. Baltimore St. Balto Md.

19. Dec 16 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1945, at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 16, 1945, to Dec 16 1945 and that I last saw him alive on December 16 1945

Immediate cause of death	DURATION
Pulmonary embolism	8 hrs
Due to: Hypertensive cardio-vascular renal disease	3 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L. Louis Mendel, M.D. M. D. or other
Address: College Park, Md. Date signed 12/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

12626

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Pro Geo Co.
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Dead on arrival
Hospital, institution, or street address where death occurred: Prince George's General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co.
City or town: Villa Heights Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5622 Landover Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Willard August Shiner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Mary A. Shiner
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): sept 26. 1884

8. AGE: Years	Months	Days	If less than one day
61			hrs. min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Printing Office
11. Industry or business: U. S. Government

FATHER
12. Name: Stewart Shiner
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mary A. Shiner
Address: Villa Heights Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 11 1945 (month) (day) (year)
Cemetery or crematory: Forest Lawn
Location: Colmar Manor Md
18. Funeral director: F. Gaeckle Sons
Address: Hyattsville Md

19. 12/8 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8 1945, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure,	
Due to Coronary Occlusion	
Renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Deputy medical Examiner
James J. Sord
M. D. or other
Address: Hyattsville Md Date signed: 12-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

12630

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Tuxedo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Tuxedo
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5411-57th ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MIRIAM B. SMITHWICK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Will R.
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 29th 1897

8. AGE: Years	Months	Days	If less than one day
48	4	15	____ hrs. ____ min.

9. Birthplace: Pittsburgh Pa. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Jason Hohensack
13. Birthplace: Martin's Ferry, Ohio

MOTHER
14. Maiden name: Carrie Campbell
15. Birthplace: N.J.

16. Informant: Will R. Smithwick
Address: 5411-57th ave. Tuxedo Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Dec 16 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Bladensburg Md.

18. Funeral director: H. H. Chambers Co.
Address: Riverdale Md

19. 12/15 19 45 Amanda Denney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 14th 19 45 at 3:30 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 11 1945 to December 14 1945
and that I last saw her alive on December 13 1945

Immediate cause of death	DURATION
Lobar pneumonia	16 hours
Due to: Complications unknown	
Due to:	
Other conditions: Neurasthenia -	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: C. Louis Mendel, M.D.
M. D. or other
Address: 4506 Ellery ave College Park, Md. Date signed 12/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12631 243.

Reg. Dist. No.

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 7 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 612 Upshur Street N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: JAYNE STARR

3.(b) Social Security Number: 577-24-9309

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Marion Starr

6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): February 28, 1919

8. AGE: Years	Months	Days	If less than one day
26	9	3	...hrs. ...min.

9. Birthplace: Hagerstown, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Jacob F. Myers
13. Birthplace: Virginia

MOTHER
14. Maiden name: Francis Miller
15. Birthplace: Virginia

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 12 - 1 - 45 (month) (day) (year)

Cemetery or crematory: To Hagerstown, Md.

Location:

18. Funeral director: Andrew K. Leo Funeral
Address: Hagerstown Md

19. Dec 1, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 1, 1945, at 5.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 24, 1945 to Dec. 1, 1945 and that I last saw her alive on Nov. 30, 1945.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr 11 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md Date signed: 12/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12632

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1021 - 6th St. S. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: WALTER TALBERT

3. (b) Social Security Number: 1577-16-7038

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (separated)

6.(b) Name of husband or wife: Naomi Talbert

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): September 30, 1897

8. AGE:

Years	Months	Days	If less than one day
48	2	8	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: William Talbert
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Mary Jones
15. Birthplace: Washington, D. C.

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 12-8-45 (month) (day) (year)

Cemetery or crematory: —

Location: to Washington D.C.

18. Funeral director: [illegible]

Address: 901 - 3rd. St. S.W.

19. Dec. 8, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 8 1945, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOV. 23 1945, to DEC. 8 1945, and that I last saw him alive on DEC. 7 1945.

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	1 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 12/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1847)

12633

CERTIFICATE OF DEATH

Reg. Dist. No. 242.

1. PLACE OF DEATH:
County: Prince George
City or town: Lanham
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred:
Under Lanham Bridge
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Woodward Farms
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Daniel Thomas

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Alice Thomas
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE: Years: 75 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm
FATHER 12. Name: John Thomas
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Graham
MOTHER 15. Birthplace: Graham
16. Informant: Daniel Thomas
Address: Bowie, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 5 1945 (month) (day) (year)
Cemetery or crematory: Carroll Cemetery
Location: Mitchellville Md
18. Funeral director: J. Gaschen & Sons
Address: Hyattsville Md.
19. Jan 4th 1946. (Date rec'd by registrar) Mrs Jack Bennett Dep. Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31 1945 at 9 55 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Hemorrhage	
Due to: Shock	
Due to: Crushed chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 12-31-45
Where did injury occur? Lanham (City or town) Pr. Geo. (County) Md. (State)
Injured at home, farm, industry, public place (where?): R.R. Bridge
Means of injury: Fell from bridge Injured at work? No

23. SIGNATURE: James L. Ford M. D. or other
Deputy Medical Examiner
Address: Forestville Md Date signed: 12-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-D)

12634

CERTIFICATE OF DEATH

Reg. Diat. No. 237

1. PLACE OF DEATH:
County Prince George
City or town Naylor, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Prince George
City or town Naylor, Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Francis Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife Martha A. Bradley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 15-1880.

8. AGE:

Years	Months	Days	If less than one day
65	3	1	..... hrs. ..... min.

9. Birthplace Prince Geo. Co. Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Not known
13. Birthplace " "

MOTHER
14. Maiden name " "
15. Birthplace "

16. Informant James W. Jr. Thomas (Son)
Address Naylor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 19 1945 (month) (day) (year)
Cemetery or crematory St. Thomas
Location Croom, Md.

18. Funeral director Ritchie Bros.
Address Upper Marlboro, Md.

19. Dec 18 1945 (Date rec'd by registrar) James B. Naylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1945, at 1.40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 1 1943 to Dec 16 1945
and that I last saw him alive on Dec 16 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 hrs
Due to Hypertensive Cardio-Vascular Renal Disease	10 yrs
Due to	
Other conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op.
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James C. Sasscer M. D. or other
Address Upper Marlboro Md. Date signed 12-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

12635

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 hrs. 35 min.
Hospital, institution, or street address where death occurred:
Prince George's Hosp.
How long in hospital or institution? 14 hrs. 35 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4114 Gallatin St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Mary B. Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife: Rev. Henry Thomas
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1869

8. AGE: Years	Months	Days	If less than one day
76			..... hrs. ..... min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Edward D. Brennaman
13. Birthplace: D.C.

MOTHER
14. Maiden name: Marion Wilson
15. Birthplace: D.C.

16. Informant: Mrs. Waldo Burnside
Address: 5214 42nd Pl. Hyattsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/14/45 (month) (day) (year)
Cemetery or crematory: Oak Hill
Location: Washington D.C.

18. Funeral director: F. Gaschi sons
Address: Hyattsville Md.

19. 12/12/45 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 - 10 19 45, at 8 35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 19 42, to Dec 10 19 45, and that I last saw h... alive on Dec 10 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to	
Due to Hypertensive Heart Dis	15 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hyattsville Md. Date signed 12/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of year of birth of deceased is shown on FILM No. I 00 JAN 29 1946

12636

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (07)

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Forestville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince Georges
City or town: Forestville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7620 Marlboro Pike
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: SAMUEL E. THOMAS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith Caroline
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Sept 25 1871 1870

8. AGE: Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business

FATHER
12. Name: William H Thomas
13. Birthplace: Md

MOTHER
14. Maiden name: Amanda Frye
15. Birthplace: Md

16. Informant: Edith C Thomas
Address: 7620 Marlboro Pike

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Dec 29 1945 (month) (day) (year)
Cemetery or crematory: Cremation at Lees
Location:

18. Funeral director: J. Wm Lees Sons
Address: 306-7th St NE Wash D C

19. 12-28-45 (Date rec'd by registrar) Thos D Suffolk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 27 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 25 1945, to 19..., and that I last saw him alive on Dec 27 1945

Immediate cause of death	DURATION
Acute Bronchopneumonia	4 Days
Due to: —	
Due to: —	
Other conditions: Chronic nephritis arteriosclerosis (Include pregnancy within 3 months of death)	unknown

Major findings of operations: none
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Thos D Suffolk M. D. or other
Address: Washington 19 DC Date signed: Dec 27 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

12637

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince Georges
City or town: Near Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Aug. 28. 1939
Hospital, Institution, or street address where death occurred:
Laurel Sanitarium
How long in hospital or institution? Since Aug 28, 1939

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mary Susanna Treadway | **3.(b) Social Security Number** None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

8.(b) Name of husband or wife: Oliver T Treadway
8.(c) If alive, give age: 75 years
7. Birth date of deceased (mo., day, yr.): February 13, 1864

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
81	9	16		

9. Birthplace: Hartford Co. Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Theodore H Welch
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Robinson
15. Birthplace: Maryland

16. Informant: Mr John H Sherman Trustee
Address: c/o Mercantile Trust Co. Balto.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-14-45 (month) (day) (year)
Cemetery or crematory: Mt Tabor Church Yard
Location: Forest Hill Harford Co.
18. Funeral director: Chas F Evans Son
Address: 118 W Mt Royal Ave
19. Dec 14 1945 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11 1945 at 3:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1945 to Dec 11 1945
and that I last saw h[er] alive on Dec. 11, 1945

Immediate cause of death	DURATION
Cerebral Arteriosclerosis	Not known
Due to	
Due to	
Other conditions: Senile Psychosis	Over 10 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Laurel Md, Date signed: 12/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-2)

12638

CERTIFICATE OF DEATH

★ Reg. Dist. No. 234

1. PLACE OF DEATH
County: Prince George
City or town: Friendly, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr George
City or town: 8032 Allentown Rd S.E.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Friendly Md
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME Francis Robert Underwood

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: wife K. Della Underwood
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 25, 1879

8. AGE: Years	Months	Days	If less than one day
66			..... hrs. ..... min.

9. Birthplace: Washington DC (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own Farm

FATHER
12. Name: Daniel Mosby Underwood
13. Birthplace: Pr Geo Co. Md

MOTHER
14. Maiden name: Mary Ellen McNantz
15. Birthplace: Wash. DC

16. Informant: Mrs K. Della Underwood
Address: 8032 Allentown, Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 12-1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Maryland
18. Funeral director: Thomas F. Murray
Address: 2007 Nichols ave S.E. Wash DC

19. Dec 9 1945 (Date rec'd by registrar) Howard J Beach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 9 1945 at 6:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1930, to Dec 9 1945
and that I last saw h.. alive on Dec 7 1945

Immediate cause of death	DURATION
Acute Congestive Heart Disease	3 days
Due to: Auricular Fibrillation	7 yrs
Due to: Arteriosclerosis	7 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E. O. Schwartzel, M.D. M. D. or other
Address: 1245 Talbot St SE Wash DC. Date signed: 12/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 114a

CERTIFICATE OF DEATH

12639

Reg. Dist. No. 230

1. PLACE OF DEATH:
County Prince George's
City or town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State U County
City or town N
(If outside city or town limits, write RURAL and give nearest town)
Street No. K N OWN (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME UNKNOWN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Unknown	Unknown

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 60			hrs. min.

9. Birthplace XXXXXX Unknown
(Town, county, and state)
10. Usual occupation Unknown
11. Industry or business

FATHER
12. Name U
13. Birthplace N

MOTHER
14. Maiden name K NOWN
15. Birthplace

16. Informant None
Address

17. Burial Date thereof JAN 10 1946.
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Evergreen
Location Bladensburg Md.
18. Funeral director F. Gaeche Sons
Address Hyattsville Md.
19. 1/10 1946 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Found December 31 19 45 at 2:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia	
Due to Hanging	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of ?
Where did injury occur? Beltsville (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) In a woods
Means of injury Hanging by the neck Injured at work?

23. SIGNATURE Deputy Medical Examiner
M.D. or other
Address Forestville, Md. Date signed 1/8/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12640
243.
Reg. Dist. No.

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs., 8 mos., 8 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 7 yrs., 8 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 900 Jackson Street N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FRANCES LOUISE VAUGHN.

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Donald Vaughn
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): June 30, 1918

8. AGE: Years	Months	Days	If less than one day
27	5	21	...hrs. ...min.

9. Birthplace: Waynesboro, Pennsylvania (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: George Albert Florence
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Ann Martin
15. Birthplace: Maryland

16. Informant: Decedent
Address:

17. Remabal (Burial, cremation, or removal. Which?) Date thereof: 12/23/45 (month) (day) (year)
Cemetery or crematory:
Location: To Riverdale, Md.
18. Funeral director: W. W. Chambers Co.
Address: Riverdale, Md.

19. Dec. 21, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21 1945, at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1938, to Dec. 21, 1945.
and that I last saw her alive on Dec. 21, 1945.

Immediate cause of death	DURATION
Pulmonary tuberculosis	7 yrs 8 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 12/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

12641

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Prince George
City or town New Hampshire Highlands
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town New Hampshire Highlands
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1118 Lancaster Rd. Takoma Pk. Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Morris Vigderhouse

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
Male	White	Jennie Vigderhouse married

6.(b) Name of husband or wife Jennie Vigderhouse
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) May 15, 1885

8. AGE: Years	Months	Days	If less than one day
60	—	—	hrs. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business
12. Name of FATHER Nathan Vigderhouse
13. Birthplace Poland
14. Maiden name of MOTHER Sarah Rappaport
15. Birthplace Poland
16. Informant Bernard Vigderhouse
Address 5912-14th St. NW
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2, 1946 (month) (day) (year)
Cemetery or crematory Ohev Sholom Cemetery
Location Washington, D.C.
18. Funeral director B. Wahrsamker & Son
Address 3501-14th St. NW Wash. D.C.
19. Dec 30 1945 Josephine M. Schaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 December 1945 at 1:28 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 October 1945 to 30 Dec 1945 and that I last saw him alive on 30 December 1945

Immediate cause of death Heart failure Sec to Carcinoma of Stomach — DURATION

Due to Carcinoma of Stomach — 4 mos

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Stomach
Date of op. 1 Oct 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel J. M. Sugar M.D.
M. D. or other
Address 4300 Kenwood Dr. Date signed 3 Dec 1945
Md. Kenmore, Md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

12642

CERTIFICATE OF DEATH

★ Reg. Diat. No. 239

1. PLACE OF DEATH:
County Prince Georges
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
Laurel Sanitorium
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D C County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20 E Street NW
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Ferguson Ward Jr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug 3, 1896

8. AGE: Years 49 | Months 4 | Days 24 | If less than one day ____ hrs. ____ min.

9. Birthplace Kentuckey
(Town, county, and state)

10. Usual occupation Auditor

11. Industry or business U. S. Govt

FATHER 12. Name William F. Ward Sr

FATHER 13. Birthplace Kentucky

MOTHER 14. Maiden name Lotta Roberts

MOTHER 15. Birthplace Tennessee

16. Informant Henry B. Wallingford

Address 20 E St NW Washington D C

17. Burial to Mayfield Ky Dec 29-45
(Burial, cremation, or removal, which?) Date of interment (month) (day) (year)

Cemetery or crematory Mayfield Ky

Location

18. Funeral director Ake L. Hamilton Co

Address 2901 14th St. N.W.

19. Dec 29 1945 M. Buschbeck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____

and that I last saw h____ alive on ____ 19____

Immediate cause of death: Cardio Congestive Heart failure — DURATION
Toxic Myocarditis
Due to Chronic alcoholism
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner
M. D. or other

Address Prestwould Hotel Date signed 12-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12643

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
5800 - L St. N.E.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5800 L St. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME: George H. Washington

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Annie Washington ?
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1873

8. AGE: Years	Months	Days	If less than one day
72			..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Beer. Cont.
FATHER 12. Name: George Washington
FATHER 13. Birthplace: Settle Baptist
MOTHER 14. Maiden name: Settie Payne
MOTHER 15. Birthplace: Va.
16. Informant: Hettie V. Williams
Address: 44 - Eggleve Jersey City, N.J.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 28 1945 (month) (day) (year)
Cemetery or crematory:
Location:
18. Funeral director: Ernest Davis & Co
Address: 1432 - You St. N.W. D.C.
19. 12-28 1945 (Date rec'd by registrar) Carrie J. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec-28- 1945 at 1:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20 1945, to Dec. 28 1945
and that I last saw h.. alive on Dec. 28 1945

Immediate cause of death	DURATION
Hypertensive	
Cardio Vascular	
Due to: Disease	?
Due to:	1
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. G. Bodden M.D.
M. D. or other
Address: 1423 - Irvin Pl. N.E. Date signed: 12-28-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

12644

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince Georges.

City or town Riverdale.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days.

Hospital, Institution, or street address where death occurred: Eugene Leland Memorial Hosp.

How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland. County Prince Georges.

City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3900 Oliver Street.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Carrie Belle Wilcox

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed.

6.(b) Name of husband or wife Mr Frank Wilcox

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 4, 1862.

8. AGE: Years 83. Months 8. Days ____ If less than one day ____ hrs. ____ min.

9. Birthplace Mass
(Town, county, and state)

10. Usual occupation Home wife.

11. Industry or business own home.

FATHER 12. Name Alonzo Gardner

13. Birthplace New York.

MOTHER 14. Maiden name Helen ?

15. Birthplace ?

16. Informant Mrs C hart.

Address

17. Burial Date thereof Dec 5, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ft Washington

Location Berwyn Md

18. Funeral director F Gaeke's sons

Address Hyattsville Md

19. Dec 5th 1945 Mrs Jas Severe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1945 at 6:07 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944, to Dec. 3 1945 and that I last saw h[illegible] alive on Dec. 3 1945

Immediate cause of death	DURATION
Uremia	5 days
Due to Renal Arteriosclerosis	Indeterminate
Due to	
Other conditions Syphilis	2 weeks

(Incinde pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L W Mallum MD
M. D. or other

Address Riverdale Md Date signed 12-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 126 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Pro Geo Co.
City or town: Bladensburg Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, Institution, or street address where death occurred: 4901 Queens Pl
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4901 Queens Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Aaron James Will

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Nov 28, 1898.

8. AGE: Years: 47 | Months: 1 | Days: 2 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Erector —

11. Industry or business:

FATHER — 12. Name: James A. Will
13. Birthplace: Penna

MOTHER — 14. Maiden name: Amanda Bobtrack
15. Birthplace: Penna

16. Informant: Edna M. Hill
Address: 3701 Perry st Mt Rainier Md

17. Disposition: transportation
(Burial, cremation, or removal. Which?) Date thereof: Dec 24. 1945 (month) (day) (year)
Cemetery or crematory: East Greenville Pa
Location: East Greenville Pa

18. Funeral director: F Gaeta & sons
Address: Hyattsville Md.

19. 12/24 1945 Amanda Daurer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 23 1945, at 5 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to gun shot wound at base of skull.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? homicide Date of 12-23-45
Where did injury occur? Bladensburg (City or town) P.G. (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: shot gun Injured at work? no

Deputy Medical Examiner

23. SIGNATURE: [signature] M. D. or other
Address: Hyattsville Md Date signed: 12-23-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

1264234
705

Reg. Dist. No.

1. PLACE OF DEATH:

County: Prince Georges

City or town: Accokeek

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Accokeek

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Julian Willett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Daisy Willett

B.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Jan 25, 1885

8. AGE: Years: 60 | Months: 11 | Days: 0 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER — 12. Name: George Washington Willett

13. Birthplace: Kentucky

MOTHER — 14. Maiden name: Mary Pinkerneil

15. Birthplace: Maryland

16. Informant: Daisy Willett

Address: Accokeek, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-29-45 (month) (day) (year)

Cemetery or crematory: Christ Church Cemetery

Location: Accokeek Md

18. Funeral director: Hewitt & Ryon

Address: Waldorf Md

19. 12-28 1945 (Date rec'd by registrar) M. P. Mudd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 28 1945, at 11:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Congestive heart failure	
Due to: Dropsy	
Due to: Bronchopneumonia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy medical Examiner

23. SIGNATURE: James F. Ford M. D. or other

Address: Hyattsville Md Date signed: 12-26-45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

12647

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4103 Gallatin St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Betty Busey Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widower

6.(b) Name of husband or wife: James Janey Williams
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 18 92

8. AGE: Years: 93 | Months: 10 | Days: | If less than one day: hrs. min.

9. Birthplace: Mansfield W. Va.
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER
12. Name: Thomas H. Busey
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Sarah McClanahan
15. Birthplace: Roanoke, Va.

16. Informant: Mrs Louis Dasheill
Address: Hyattsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 4, 1946 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Baltimore Maryland

18. Funeral director: F. Gasch's Sons
Address: Hyattsville Maryland.

19. Jan 3 1945 (Date rec'd by registrar) James Busey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31 1945 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from many years 19 to Dec 31 1945 and that I last saw her alive on Dec 31 1945

Immediate cause of death: Arteria Sclerosis and Cerebral hemorrhage — DURATION: 4 years

Due to: — DURATION: immediate

Due to: — DURATION:

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operation: ✓
Date of op.:
Autopsy results: ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ✓
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Dwight Palmer M.D.
M. D. or other
Address: Hyattsville Md. Date signed: Jan

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

12648

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prs Geo co

City or town: Hyattsville md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Prs Geo co

City or town: Hyattsville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3813 Oliver st

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Jay Lee woodside

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: allie woodside

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): sept 5, 1884

8. AGE: Years: 61 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Brick layer & Builder

11. Industry or business:

FATHER — 12. Name: John woodside

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: alice Thompson

MOTHER — 15. Birthplace: North Carolina

16. Informant: Allie woodside

Address: 3813 oliver st Hyattsville Md

17. Disposition: transportation (Burial, cremation, or removal, Which?) Date thereof: Dec 7, 1945 (month) (day) (year)

Cemetery or crematory: Charlotte

Location: North Carolina

18. Funeral director: F Gaeck's sons

Address: Hyattsville Md

19. Dec 6 1945 (Date rec'd by registrar) James Severy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 5 1945 at 6.35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-3-45 1945, to 12-5 1945 and that I last saw h. 12. alive on 12-5-45 1945

Immediate cause of death	DURATION
Influenza	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John P. Ann M.D. M. D. or other

Address: Hyattsville Md Date signed: 12-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (142-C)

CERTIFICATE OF DEATH

12649

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Used on arrival

Hospital, institution, or street address where death occurred:
Prince Georges General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Fairdale
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Landover Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Beulah Yates

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6.(b) Name of husband or wife: Chester L. Gates

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug 7, 1910

8. AGE:	Years	Months	Days	If less than one day
	35	4	21	..... hrs. ..... min.

9. Birthplace: Harrison Co. W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Asa B. Gallaher
13. Birthplace: Belmont Co., Ohio

MOTHER
14. Maiden name: Mary E. Crain
15. Birthplace: Harrison Co. W. Va.

16. Informant: Chester L. Yates
Address: Fairdale Md

17. Burial, cremation, or removal? Burial Date thereof: 12-29-45 (month) (day) (year)

Cemetery or crematory: Shinnston Cemetery

Location: Shinnston W. Va.

18. Funeral director: W. W. Chambers Co.

Address: Rhode Island Ave

19. 12/29 1945 (Date rec'd by registrar) Amanda Downey, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 28 1945, at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Hemorrhage	
Shock	
Due to: Ruptured ectopic	
Pregnancy	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other

Address: Forestville Md Date signed: 12-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

12650

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town Mt. Rainier, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3710 Wells Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME CATHERINE V. YOUNG

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife Roy R.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 20, 1887

8. AGE: Years	Months	Days	If less than one day
58			..... hrs. ..... min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business own home
FATHER 12. Name James Roche
13. Birthplace Washington, D. C.
MOTHER 14. Maiden name Hettie Ridgeway
15. Birthplace Washington, D. C.
16. Informant Edith M. Dore
Address 1333 Ritchie Pl. N. E.
17. Burial (Burial, cremation, or removal. Which?) Date thereof December 29, 1945 (month) (day) (year)
Cemetery or crematory Oak Hill Cemetery
Location Washington, D. C.
18. Funeral director William J. Malley
Address 3200 - R. I. Ave. Mt. Rainier, Md.
19. Dec. 28" 1945 James E. Sevey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1945, at 2:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19, 1945, to December 27, 1945 and that I last saw h... alive on December 19, 1945

	DURATION
Immediate cause of death: Cardiovascular renal disease	Several years
Due to:	Several years
Due to: Uterine fibroids, non-malignant	
Other conditions: Abdominal (Mass) Tumor Case	Several years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Mt. Rainier, Md. Date signed 12/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Coroners Dr James Boyd, autopsies by the early morning hours 12/31/45 and will appear.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12651

★ Reg. Dist. No. 243.

1. PLACE OF DEATH:
County: Prince George's
City or town: Glenn Dale, Maryland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 702 - 4th St. S.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: ALONZO YOUNGER

3.(b) Social Security Number: 579-05-0741

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Louise Younger
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): June 7, 1905

8. AGE: Years: 40 | Months: 5 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Halifax, Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: James R. Younger
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Minnie Hendricks
15. Birthplace: Virginia

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 2 1945 (month) (day) (year)
Cemetery or crematory: Washington,
Location: D.C.

18. Funeral director: Eugene Ford
Address: 1213 - 4th ST. S.W.

19. Dec. 2, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 2 1945, at 6:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOVEMBER 14 1945, to DEC. 2 1945
and that I last saw him alive on DEC. 1 1945

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	1 yr 6 ms
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 12/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15